Whispers of Hope Horse Farm

Summer Camp 2025

Registration and Release Form

$150.00 per week

Registration: Jr. Volunteers and Regular Day Campers: Ages 6-9 ☐ or Ages 10+ ☐

Camp Week(s) Requested: ☐ **June 3-6** ☐ **June 10-13** ☐ **June 17-20** ☐ **June 24-27**
☐ **July 1-3** ☐ **July 8-11** ☐ **July 15-18** (☐ **June 3-6 advanced camp*)**

Name: _____ Age of Camper _____ **BY APPROVAL ONLY***

Street: _____ City: _____ State: _____ Zip Code: _____

Cell Ph: _____ Parent Work Ph: _____ Emergency Ph: _____

Email _____ Parent's name: _____

Camp T-shirt: Please circle one/or fill in box Youth **XS S M L** Adult **S M L XL**

Fee paid $ _____ check _____ or cash _____ for each camp. (Due at time of registration)

Allergies: _____

Please write special requests or instructions on the back of this form and attach any other information about the youth that you think is necessary.

All campers should have totally enclosed shoes/boots and long pants for riding. Sunscreen and hat optional. Please check brochure for additional information and feel free to contact office
Phone #'s: 940-696-8044. or Jaclyn's cell phone: 940-642-1417

LIABILITY RELEASE:

I wish to participate or have my child or ward participate in the Whispers of Hope Horse Farm Program and I hereby acknowledge that I have legal authority to enroll said person in this program. I acknowledge the risks and possible risks of horseback riding, however, I feel that the potential benefits to myself, my child or my ward are greater than the risk assumed. I hereby, intending to be legally bound for myself, my heirs, assigns, executors, or administrators, waive and release forever all claims for damages against Whispers of Hope Horse Farm, its Board of Directors, Officers, Agents, Instructors, Therapists, Aides, Volunteers, Employees and Owners of horses for any and all injuries, illnesses, and/or losses sustained by myself/my son/my daughter/my ward or my horse, while participating in Whispers of Hope Horse Farm Programs on site or away. I agree to indemnify Whispers of Hope Horse Farm for any and all claims arising directly or indirectly out of my use of Whispers of Hope Horse Farm horses, equipment or facilities.

Photo Release: I hereby authorize the use and reproduction by Whispers of Hope Horse Farm of any and all photographs and any other audiovisual materials taken of me/my son/my daughter/my ward for promotional printed material, educational activities or for any other use for the benefit of the program, with the understanding that discretion will be used at all times.

_____ ☐Myself ☐Child (under 18) ☐Ward
Participate Name (Print Clearly)

_____ ☐Myself ☐Parent ☐Legal Guardian ☐Caregiver
Authorizing Signature

_____ _____
Print Name of Authorizing Signature Date

*****WARNING*****

UNDER TEXAS LAW (CHAPTER 87, CIVIL PRACTICE AND REMEDIES CODE), AN EQUINE PROFESSIONAL IS NOT LIABLE FOR AN INJURY TO OR THE DEATH OF A PARTICIPANT IN EQUINE ACTIVITIES RESULTING FROM INHERENT RISKS OF EQUINE ACTIVITIES.

Please Complete Other Side

Whispers of Hope Horse Farm

Camper Emergency Medical Form

Camper Authorization for Emergency Medical Treatment

In the event medical aid/treatment is required due to illness or injury during the process of receiving services or while being on the property of the agency, I authorize Whispers of Hope Horse Farm to:

(1) Secure and retain medical treatment and transportation if needed
(2) Release any records upon request to the authorized individual or agency involved in the medical emergency treatment.

Camper's _____ Date of Birth: _____

Parent/Guardian: _____

Home Phone: (_____) _____ Work Phone: (_____)_____

Cell Phone: (_____) _____ E-Mail: _____

Address: _____ City: _____

State: _____ Zip: _____

Emergency Contact #1: _____ Phone: _____

#2: _____ Phone: _____

Physician's Name: _____

Preferred Medical Facility: _____

Health Insurance Company: _____ Policy#: _____

Camper' Disability: _____

_____

Describe any medical condition requiring special precautions or treatment and any medication with dosage:

_____

_____

Consent Plan

This authorization includes X-ray, surgery, hospitalization, medication and any treatment procedure deemed "life saving" by the physician. This provision will only be invoked if the person below is unable to be reached.

Date: _____ Consent Signature: _____

Client, Parent, Guardian or Adult Caregiver

Print Name: _____

Non-Consent Plan

I do not give my consent for emergency medical treatment/aid in the case of illness or injury during the process of service or while being on the property of the agency. In the event emergency treatment/aid is required, I wish the following procedures take place: _____.

Date: _____ Consent Signature: _____

Client, Parent, Guardian or Adult Caregiver

Print Name: _____