		Co	onfidential F	Riding App	lication	and	d Medical H	istory Fo	rm	
Riders na			ie:						Over 18 (Check Box)	AFFINITY
		Contact Numbers:						Age:		Risk Management
I am applying to r	ide w								(if under 18))
I agree to the follo			ly ride the hor	rse in a safe	and cor	trolle	ed manner			
			-				elmet and the	correct fo	otwear at a	all times
							and follow all i			
			tructor/Guide		my ride	witho	out refunding a	any fee if I	do not co	mply with any c
Diding ovporionoo		The nur	nber of times	the rider has	s ridden	in the	e last 12 mon	ths		
Riding experience							as ridden in to			
0 - 10			0 - 20	0 - 50	0 🗍 50 - 100		- 100		100 +	
Little experience S		Some e	experience Average		experier	ience Experienc		enced	Very	experienced
In the case of any	emer	gency the fol	lowing inform	ation is inter	nded to a	assist	t:		·	
Name and telephor	ne nur	nbers of cont	act people. *	** Legal gardiar	details m	ust be	provided if rider	is under 18 y	ears of age	
Emergency	ct name	Relatio	onship with ri	der		Mobile	Hom	ne	Work	
L										
Are there any lear	ning c	difficulties that	t need to be a	discussed, s	o the Ins	struct	ors/Guides ar	e able to a	iccommod	ate accordingly
Please describe:										
<u>Do you (or your c</u>	child)	suffer from	any of the f	ollowing?			NO (Please f	tick if appli	cable)	
Please tick: Any	pre-ex	isting medical	or other condit	ion that may a	affect or r	isk otl	her persons or	myself.		1
Asthma	Diabetes		Epilepsy / F	its 🗌 Fain	Fainting		Blackouts		bility	Back injury
Heart Condition	Blood Condition		Pregnancy	Dizz	Dizziness		Migraines		ven Pupils	Medications
Allergic Reactions	R	ecent injury								
Allergies										
Please describe ale and reaction	ergy									
Tetanus Immunis It is particularly im		_	e dealing with	horses are	immunis	ed a	gainst tetanus	s. Tetanus	is normal	ly given at five
years of age as Tr Medication	riple a	intigen or CD	T and at fiftee	en years of a	age as A	DT. \	Year of last te	tanus imm	unisation	
Is it necessary for	r you (or your child	to carry their	own medicat	tion at a	l time	es?			
Name of drug: Fr						':		Dosa	ge:	
Consent To Medi I authorise the inst			administer fi	rst aid and c	all an ar	nbula	ance. I agree t	to bear any	y cost ther	eby incurred.
Signature of Rid	er				Signa	ature	of Legal Gua	rdian (if pa	rticipant is	s U/18)
								Date	:	
				Privacy State	ment – Pr	ivacy	Act 1998		L	

By completing this form you are supplying **the Provider** with personal information about yourself. This information is needed to ensure your safety during your time with us. **The Provider** is required to collect this information by our insurance company and by the department of Workplace Health and Safety. This information you provide will not be supplied to any other organisation or used for any other purpose than that which is stated above