NATIONAL REINING HORSE ASSOCIATION
PARA REINING PHYSICIANS STATEMENT

I, _____ (Licensed Medical Physician) attest that my patient,

_____(NRHA Member) has a diagnosed mental or physical condition
Member Name /NRHA Member Number
that limits his/her ability to ride a horse astride.

PRINT NAME_____ Signature:_____

Address _____

City_____ State_____ Zip_____ Phone: _____

EXHIBITOR/PARTICIPANT

I AM AWARE THAT PARTICIPATION IN EQUESTRIAN ACTIVITIES CAN BE HAZARDOUS ACTIVITIES AND I AM VOLUNTARILY PARTICIPATING IN THESE ACTIVITIES WITH THE KNOWLEDGE OF THE DANGER INVOLVED, AND AGREE TO ASSUME ANY AND ALL RISKS OF BODILY INJURY, DEATH OR PROPERTY DAMAGE.

I VERIFY THIS STATEMENT BY INITIALING HERE: _____
Participant

_____
Parent/Guardian

As consideration for being permitted to participate in these activities, use the facilities and use equipment that is medically authorized, I hereby agree that I, my assignees, heirs, distributees, guardians, next of kin, spouse and legal representatives will not make a claim against, sue or attach the property of NRHA an NRHA AFFILIATE, and/or their employees, helpers and volunteers, from any and all actions, claims, or demands that I, my employees, my assignees, heirs, distributees, guardians, next of kin, spouse and legal representatives now have or may hereafter have for injury or damage resulting from my participation in the activities described above.

I agree to be responsible and assume liability for anyone I invite or cause to be on the horse show premises and agree to advise them of this waiver.

I agree to re-submit this form if my medical condition changes and relinquish my eligibility if I no longer meet the stipulations above.

I HAVE CAREFULLY READ THIS AGREEMENT AND FULLY UNDERSTAND ITS CONTENTS. I AM AWARE THAT THIS IS A RELEASE OF LIABILITY AND A CONTRACT BETWEEN MYSELF AND THE NRHA AND IT'S AFFILIATES AND SIGN IT OF MY OWN FREE WILL.

(*Signatures below indicate that you have read and understand the above.*)

PRINT NAME_____ Signature:_____

Address _____

City_____ State_____ Zip_____ Phone: _____