

APPLICATION FORM FOR RIDERS, VAULTERS AND CARRIAGE DRIVERS

(PLEASE USE BLOCK CAPITALS AND RETURN TO GROUP ADDRESS BELOW)



To be completed by RDA group before being given to applicant	
GROUP NAME	Chigwell Riding Trust For Special Needs
CHARITY NO	212644
CONTACT NAME	Mrs Deborah Hall
ADDRESS	Grange Farm Lane Chigwell Essex IG7 6DP
EMAIL	deborah@chigrade.org.uk
TEL NO	020 8500 6051

All information will remain confidential, for use by RDA only. All the information you provide will enable us to contact you in relation to your activities with RDA. This may include sending you important information, which relate specifically to your involvement in your group or any other activities you may take part in within RDA.

1 RIDER DETAILS

First Name		Last Name	
Date of Birth		Gender	
Address			Postcode
Email Address			
Telephone		Mobile Number	
Riding	Do you have any previous experience with an RDA Group? If YES, what is the Group's name?	Yes	No
School/Training Centre	Are you joining as part of a School or Training Centre? If YES, what is the School/Centre name, contact and phone number?	Yes	No

2 SPECIFIC INFORMATION ABOUT YOU

What is your disability, condition or diagnosis?			
Are you on any medication that may cause side effects during your time at RDA? If so, what is the medication and potential side effect(s)?			
What, if any, conditions do you have that may need special attention during your activities with RDA? (It is the applicant's responsibility to ensure that we have knowledge of all issues that might pose a problem)			
Please provide name and contact details of a Medical Professional who knows you and your medical conditions:			
Height		Weight	

3 ADDITIONAL INFORMATION

Speech	Do you have problems with speech?	Yes	No
Eyesight	Do you have problems with eyesight?	Yes	No
	Do you wear glasses / contact lenses?	Yes	No
Hearing	Do you have difficulty with hearing?	Yes	No
	Do you wear a hearing aid?	Yes	No
Instructions	Do you have difficulty understanding instructions?	Yes	No
Walking	Do you need help walking?	Yes	No
	Do you use walking aids?	Yes	No
	Do you wear orthopedic appliances?	Yes	No
	Do you use a wheelchair?	Yes	No
	Would weight-bearing be a problem?	Yes	No

If you have answered 'Yes' to any of the above, please give any additional information that you think would be useful for the RDA Group:

4 DECLARATION

- I wish to apply as a rider of an RDA Group and confirm that all details given are accurate, to the best of my knowledge.
- I agree that should the Group Coach require additional information on my medical condition, at any time, I will provide what is required and be willing to get a medical report from a Medical Professional who is familiar with my condition if necessary. I understand that I may be required to pay a fee for such a report.
- I confirm that I will advise you immediately if any of the information provided on this form changes in any way.
- I recognise that this activity involves risk and that I, the rider, should take all reasonable precautions and follow all advice properly given.
- I understand by nature horses are unpredictable and that means they may react to a situation or to the local environment in such a way that a rider may be unseated in an accident.

In the absence of any negligence on the part of the RDA or the Group, I accept that no liability will attach to either of them.

Photos/Videos	I give consent to my photograph being taken during RDA activities for training and/or publicity (including websites, social media, newsletters and marketing materials for the group and RDA UK). I give this consent acknowledging the photos will not be given to a third party without my explicit consent.	Yes	No
Signature	Rider/Parent/Guardian (Delete as appropriate)	Date	

5 APPLICANT'S PARENT OR LEGAL GUARDIAN CONFIRMATION OF CONSENT TO JOIN RDA

(if the form has been completed by a parent/legal guardian or the applicant is under 18 years old)

Name		Relationship to Applicant	
Address		Home Number	
	Postcode	Mobile Number	

Emergency Contact Details

If you do start riding at RDA. It's important we know who to contact in case you are injured or become ill.

By ticking this box I confirm that I have consent of the individual listed above to be contacted in the case of an emergency during the course of RDA activities.

Emergency Contact Name & relationship to the applicant.		Emergency contact number	
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RDA Group Use:

Date Application Received: _____

Is application approved or declined? (delete as applicable)

APPROVED / DECLINED

Is Approval Subject to Trial Period? Y / N

If Yes - Trial End Date: _____

APPLICATION REVIEW DATE (At least every 3 years) _____