FELLOWSHIP FARM, LLC

2026

MEDICAL AND EMERGENCY INFORMATION

NAME: _____ SEX_____(M) _____(F)

ADDRESS: _____

CITY: _____ STATE _____ ZIP _____

EMERGENCY CONTACT NAME: _____ CELL #: _____

DATE OF BIRTH: _____

CHRONIC AILMENTS: (LIST ALL) ALLERGIES: (LIST ALL)

_____ _____

_____ _____

DO YOU CARRY AN EPIPEN, AND IF YES, WHERE IS IT LOCATED: _____

CURRENT MEDICATIONS AND DOSAGE, IF ANY: _____

_____

DETAILS: _____

UNDER NORTH CAROLINA LAW, AN EQUINE ACTIVITY SPONSOR OR EQUINE PROFESSIONAL IS NOT LIABLE FOR AN INJURY TO OR THE DEATH OF A PARTICIPANT IN EQUINE ACTIVITIES RESULTING EXCLUSIVELY FROM THE INHERENT RISK OF EQUINE ACTIVITIES. CHAPTER 99E OF THE NORTH CAROLINA GENERAL STATUTES.

I UNDERSTAND THAT RIDING AND THE CARE OF HORSES IS A HIGH-RISK SPORT AND THAT I AM PARTICIPATING AT MY OWN RISK. I HEREBY ASSUME ALL RISK AND RELEASE AND HOLD HARMLESS FELLOWSHIP FARM, THE OWNERS OF THE FACILITY, INSTRUCTORS, EMPLOYEES AND VOLUNTEERS FROM ANY AND ALL LIABILITY FOR ANY ACCIDENTS, INJURIES, ILLNESS, DEATH, DAMAGE OR THEFT TO HORSES, EQUIPMENT, SPECTATORS OR PARTICIPANTS.

I CONFIRM THAT I AM PHYSICALLY FIT AND HAVE NO MEDICAL CONDITIONS THAT WOULD PREVENT ME FROM SAFELY PARTICIPATING IN HORSEBACK RIDING.

I CONSENT TO EMERGENCY MEDICAL TREATMENT IF NECESSARY AND AGREE TO BEAR ALL COSTS.

_____ _____

PRINTED NAME DATE

_____

SIGNATURE (Parent/Guardian signature if rider under 18 years)

PLEASE MAKE SURE YOU HAVE FILLED IN ALL THE NECESSARY INFORMATION.