Long Island Dressage Association

CLINIC APPLICATION: HEIDI LEMACK

Dressage

February 12, 2023

Finally Farm,

782 Twomey Ave., Calverton, NY

Rider Name: _____ **Owner:** _____

Street: _____ Street: _____

City/State/Zip: _____ City/State/Zip: _____

_____ _____

Phone: _____ Phone: _____

E-mail: _____ E-mail: _____

Horse Name: _____

Age: _____ Sex: _____ Breed: _____

Level of Rider/Horse_____

Fee per ride: $135(LIDA member**) $155**(non-member)

AUDITING: FREE FOR LIDA MEMBERS ~ NON-MEMBERS $20.

TOTAL_____ **Payment due by 2/6/2023**

***NO REFUNDS WILL BE ISSUED UNLESS RIDERS' SPOT IS FILLED**

Long Island Dressage Association
PO Box 507
Calverton, NY 11933

www.lidressage.com
admin@lidressage.com

Long Island Dressage Association

I agree to hold all property owners of **FINALLY FARM** and any of their employees, the **LONG ISLAND DRESSAGE ASSOCIATION** and any volunteers, officers, and all employees free from any claim of whatever nature that may be occasioned by the horses exhibited by me, and to repay property owners on demand for all damages that they may sustain by any reason of any claim or demand occasioned as aforesaid. I further agree to wear an appropriate protective helmet at all times when riding in this dressage clinic with **Heidi Lemack.**

Rider's Signature: _____

Parent/Guardian Signature (If rider is a minor): _____

Owner (If different): _____

Person To Contact in Case of Emergency: _____

Phone: _____

MEDICAL RELEASE

Adult Rider: If emergency medical care is required for myself, and if I or an accompanying spouse or relative, am not able to convey permission in a timely manner, then the undersigned authorizes appropriate medical care as deemed necessary by emergency medical personnel, a physician, or the medical facility providing treatment. I have read this entire release and agree to it.

Name (Print): _____

Signature/Date: _____

Minor Rider: If emergency medical care is required for (child's name) _____ and if permission is not available in a timely manner, then the undersigned authorizes appropriate medical care as deemed necessary by emergency medical personnel, a physician, or the medical facility providing treatment. I have read this entire release and agree to it.

Name of Parent/Guardian (Print): _____

Signature/Date: _____

1. Management reserves the right to refuse any entry.
2. Cruelty to or the abuse of a horse by any person is forbidden. Management may bar violators from further participation for the remainder of the clinic.

Long Island Dressage Association

Make Checks Payable to LIDA /Mail Form, Payment, and Coggins to

Long Island Dressage Association
PO Box 507
Calverton, NY 11933