



Clinic Participant Application

Shayla Smock • Clinton Anderson Professional Clinician
915 County Road 423, Stephenville, TX 76401
shayla@downunderhorsemanship.com • 254-459-0605

Medical History and Emergency Contact

Name: _____ Date of Birth: _____ Age: _____

Contact # _____ Female Male

Contact in Case of Emergency:

Name: _____ Phone: _____

Relationship: _____ Cell Phone: _____

Has your doctor placed any restrictions on your activities? Yes No

If yes, please explain: _____

Are there any reasons why you should not participate in the clinic? Yes No

If yes, please explain: _____

Do you have any allergies? Yes No

If yes, please explain: _____

Current Medications: _____

Do you have or have you had any of the following in the last 12 months? (If yes please explain)

	Yes	No	Explanation		Yes	No	Explanation
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	_____	Hypoglycemia	<input type="checkbox"/>	<input type="checkbox"/>	_____
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	_____	Impaired Hearing	<input type="checkbox"/>	<input type="checkbox"/>	_____
Blood Clots	<input type="checkbox"/>	<input type="checkbox"/>	_____	Impaired Vision	<input type="checkbox"/>	<input type="checkbox"/>	_____
Convulsions	<input type="checkbox"/>	<input type="checkbox"/>	_____	Infectious Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Depression	<input type="checkbox"/>	<input type="checkbox"/>	_____	Mental Illness	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____	Muscle/Joint Disorders	<input type="checkbox"/>	<input type="checkbox"/>	_____
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	_____	Neck/Back Injuries	<input type="checkbox"/>	<input type="checkbox"/>	_____
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	_____	Need Special Equipment	<input type="checkbox"/>	<input type="checkbox"/>	_____
Fainting	<input type="checkbox"/>	<input type="checkbox"/>	_____	Pregnancy (currently)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Head Injury	<input type="checkbox"/>	<input type="checkbox"/>	_____	Severe Pain	<input type="checkbox"/>	<input type="checkbox"/>	_____
Skin Disorders	<input type="checkbox"/>	<input type="checkbox"/>	_____	Heart/Cardiac Condition	<input type="checkbox"/>	<input type="checkbox"/>	_____
Surgeries	<input type="checkbox"/>	<input type="checkbox"/>	_____	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____
Unconsciousness	<input type="checkbox"/>	<input type="checkbox"/>	_____				

I acknowledge the clinics will be physically demanding and I am able to participate.

Signature _____

Date _____



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Requirements and Checklist

My Personal Details:

- I am at least 18 years old.
- I understand that this is a physically demanding clinic. I am healthy and able to participate in the clinic.
- I will be responsible for the health, care, cleaning stalls and feeding of my horse throughout the entire clinic.

My Riding Ability:

- I am confident riding my horse on a loose rein at the **walk, trot and canter** in a group setting.
- I am confident cantering my horse on a loose rein in a group setting with other horses.
(Important note: If you are not able to confidently canter your horse on a loose rein in a group environment, you may be asked to sit out for a portion of the clinic. No refunds will be given.)

Date I last cantered my horse on a loose rein: _____

My Horse's Ability:

- I am participating with a horse, not a donkey or a mule.
- My horse is a mare or gelding.
- My horse is not a stallion.
- My horse that I am participating on has had at least 60 rides.
- My horse is reasonably manageable, both on the ground and under saddle.

Required Documentation:

- I agree to bring with me a **photocopy** of my horse's current negative **Coggins test**. This copy will be retained by the Clinician. ((REQUIRED regardless of crossing state lines))
- I agree to bring with me a **photocopy** of my horse's current **Health Certificate**. This copy will be retained by the Clinician. ((REQUIRED regardless of crossing state lines))

Required Equipment:

I understand that I MUST have the following equipment in order to participate in the clinic. I understand that the Clinician will not bring product that is available for purchase. Not having this required equipment will void registration.

- Riding boots.** Proper riding boots with a heel are required. No flip flops, tennis shoes or footwear other than approved riding boots will be allowed in the arena.
- Downunder Horsemanship Rope Halter and 14' Lead rope—NO OTHER BRANDS ACCEPTED.**
- Handy Stick and String—4ft stick with detachable 6ft string.**
- Bridle with Snaffle Bit and chin strap (Mecate reins or loop reins with a spanker are highly recommended). NO SHANK BITS.**
- Well-fitting saddle and saddle pad with correctly sized girth.**

I certify that I have read the requirements and information presented to me above.

Signature

Date



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Clinic Policies

Personal Photos:

Photos are meant to be for your personal use only, not for commercial purposes or public viewing. Absolutely no video cameras or recording.

Other Policies:

No dogs permitted at the clinic facility at any time. No Stallions, Mules or Donkeys allowed. Appropriate footwear is required at all times during your clinic. The same horse and rider combination who sign up for the clinic is to participate in the entire clinic. There will be no changes of riders and horses during the clinic. Applicants must be a minimum of 18 years of age.

Payment Policy:

50% of fees are required at sign up. Clinic must be paid in full 60 days prior to start date or the reservation may be turned over to the next applicant on the waiting list.

Helper Policy:

Each clinic participant is permitted to have one helper accompany them at the clinic. Your helper needs to be registered during check in with the Clinician. They should be someone who is supportive of your horsemanship needs and can help with tacking, grooming, cleaning stalls, etc. Helpers are not allowed to groundwork or ride your horse at any time during the clinic.

I agree to the above policies by initialing here: _____

Application Policy:

Acceptance is subject to application and review and approval. A full refund will be given if the application cannot be accepted. This application must accompany the deposit.

By signing, I acknowledge and agree to the above policies.

Signature

Date



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GENERAL: Safety Helmet / Protective Headgear Statement

Read Carefully Before Signing

Name

Address

I, for my self and/or on behalf of my child or legal ward, have been fully warned and advised by Shayla Smock (hereafter, "Clinician") that I should purchase and wear properly fitted and secured ASTM-standard/SEI-certified protective headgear (helmet and strap) that is designed for use by equestrians when riding or near horses or ponies in order to reduce the severity of some head injuries and possibly prevent death from happening as a result of a fall or other occurrences. I am NOT relying on Clinician or anyone affiliated with Clinician to provide a certified equestrian helmet or headgear for me, to check any helmet or strap that I may wear or to monitor my compliance with this suggestion at any time—*now or in the future*. **If I choose to wear an ASTM-standard/SEI-certified helmet and headgear, or if I choose not to, this is my decision alone.**

I HAVE READ THIS STATEMENT CAREFULLY BEFORE SIGNING.

Signature

Date