

**Due West Therapeutic Riding Center
Participant Application**

Today's Date: _____

Participant's Full Name: _____

Date of Birth: _____ Gender: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Phone # Home () _____ Cell () _____ Work () _____

Participant's email: _____

Primary Contact Person- Who should we notify of cancelled classes or other timely information?

Name: _____ Email: _____

Phone # Home () _____ Cell () _____ Work () _____

If Applicant is under 18 years old or has a legal guardian, please provide the following information:

Father/ Legal Guardian Full Name: _____

Mailing Address (if different than participant): _____

City: _____ State: _____ Zip: _____

Phone # Home () _____ Cell () _____ Work () _____

Email: _____

Mother/ Legal Guardian Full Name: _____

Mailing Address (if different than participant): _____

City: _____ State: _____ Zip: _____

Phone # Home () _____ Cell () _____ Work () _____

Email: _____