

APPLICATION FORM FOR RIDERS AND CARRIAGE DRIVERS

PLEASE USE BLOCK CAPITALS AND RETURN TO ADDRESS BELOW

2a(9)(a)

RDA



GROUP NAME	GADDESSEN PLACE
CHARITY NO	1074313
NAME	The Group Organiser
ADDRESS	Briden's Camp Hemel Hempstead, Herts, HP2 6EX
TEL NO	08452 415309

Confidential information for use by relevant RDA personnel only
Applicants should note that this information may be stored on a computer system; the form will be held securely in Group records

A REVIEW OF THE CONTENTS OF THIS FORM WILL NORMALLY BE REQUESTED AFTER 3-5 YEARS. RDA RESERVES THE RIGHT TO REFUSE ANY RIDER OR CARRIAGE DRIVER ON GROUNDS OF HEALTH AND SAFETY AT ANY TIME
THIS FORM MAY NEED TO BE REVIEWED IN THE EVENT OF THE RIDER/CARRIAGE DRIVER APPLYING FOR AN RDA HOLIDAY

Next Recommended date for Review: _____

If you are under 18 years or someone else normally completes your paperwork for you, it should be completed and signed on your behalf by your parent or guardian.

1 APPLICANT'S DETAILS

Surname, First Name	
Date of Birth	
Address	
Telephone Number	

2 PERSONAL INFORMATION

Height	Weight		
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 simple instructions ?	Yes	No
Walking	Do you need help with walking ?	Yes	No
	Do you use walking aids ?	Yes	No
	Do you wear orthopaedic appliances ?	Yes	No
	Do you use a wheelchair ?	Yes	No
Riding/Carriage Driving	Would weight-bearing be a problem ?	Yes	No
	Do you have any previous experience with an RDA Group ?	Yes	No
	If YES, have you passed any proficiency tests ?	Yes	No

Please give any other information that you think would be useful

3 MEDICAL INFORMATION(THIS DOES NOT CONSTITUTE CONSENT)

This should be completed by a Medical Professional who is familiar with and understands your medical problems

Details of Specific Disabilities

Note of special Problems (eg Allergies, Asthma, Autism, ADHD, Balance, Circulation, Diabetes, Epilepsy etc)

MEDICAL PROFESSIONAL COMPLETING SECTION 3 ABOVE

Name	
Appointment	
Address	
Telephone Number	
Signature	

4 APPLICANT'S SCHOOL OR TRAINING CENTRE (if applicable)

Name	
Address	
Telephone Number	
Person to contact	

5 APPLICANT'S PARENT OR GUARDIAN

Name	
Address	
Home Telephone Number	
Emergency contact Number	

6 DECLARATION (to be completed by you or, on your behalf, by your parent or guardian)

I wish to join the Group as a rider/carriage driver and agree that the details of my medical history, which will assist the Group Instructor, may be disclosed by my medical professionals.
 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/carriage driver, should take all reasonable precautions and follow all advice properly given.
 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.

Do you agree that photographs/videos taken during Group activities may be used for training/publicity?

Date	
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Signature	
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Rider/Carriage

Driver/Parent/Guardian (Delete as appropriate)
