



SpringHaven 2023 Summer Horse Camp Registration Form

Section 1: Child & Guardian Information

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|--|---|--------|------------|
| Child's First Name: | Last Name: | | |
| Age: | <input type="checkbox"/> Male / <input type="checkbox"/> Female | | |
| Date of Birth: | | | |
| Child's Horse Experience: <input type="checkbox"/> N/A <input type="checkbox"/> Pony/Trail Ride <input type="checkbox"/> Lessons <input type="checkbox"/> 4-H <input type="checkbox"/> Family Ownership | | | |
| Legal Guardian's First Name: | Last Name: | | |
| Legal Guardian's First Name: | Last Name: | | |
| Day Time Contact Number: | Cell Phone Number: | | |
| Address: | | | |
| Street: | City: | State: | Post Code: |
| Email address: | | | |
| Do you give permission for anyone else to pick-up your child? (If yes, please provide details): <input type="checkbox"/> Yes / <input type="checkbox"/> No | | | |
| Do you give permission for SpringHaven Counseling Center to use images of your child for promotional materials/media? <input type="checkbox"/> Yes / <input type="checkbox"/> No | | | |
| How did you discover SpringHaven Equine Program was offering a summer horse camp? <input type="checkbox"/> Website <input type="checkbox"/> Social Media <input type="checkbox"/> Flyer <input type="checkbox"/> Newspaper <input type="checkbox"/> Word of Mouth <input type="checkbox"/> Other: _____ | | | |
| Legal Guardian Signature: _____ Date: _____ | | | |

Section 2: Camp Session Selection

Please select to confirm the camp session your child would like to attend:

Session 1: June 12th -15th from 8:30am-12:00pm

Section 3: Payment

Due to limited capacity, spots will only be reserved upon payment

Option 1: Mail check, registration form, consent form, and emergency medical form to SpringHaven Counseling Center

Mailing Address: PO Box 265
Mt. Eaton, OH 44659

Address: 15550 Durstine Road
Dundee, OH 44624

Check Payable to: SpringHaven Counseling Center

Option 2: Credit Card

Mail registration form, consent form, and emergency medical form to SpringHaven Counseling Center

Name on Card:

Mastercard / Visa / Discover

Credit Card Number:

Expiration Date:

CVS:

Cardholder Signature: _____ **Date:** _____