

**LAKE OSWEGO HUNT  
2008 HORSE TRIALS  
ENTRY FORM**



**HORSE TRIALS DATE:** \_\_\_\_\_

Horse's Name \_\_\_\_\_  Mare  Gelding  Stallion (*check one*)

Rider's Name \_\_\_\_\_

Circle Division:      Trot-a-Trail              Beginning Novice              Novice              Training

Circle Age Group:      Junior              Senior

Entry Fee      \$ \_\_\_\_\_

Stabling \_\_\_\_\_ Please indicate expected arrival time: Date \_\_\_\_\_ Time \_\_\_\_\_

Add'l Tests \_\_\_\_\_

TOTAL FEES      \$ \_\_\_\_\_

**Make checks payable to:** Lake Oswego Hunt, Inc.  
**Mail entries to:** Sandee Archer, LOH HT Secretary  
15905 Oswego Shore Court  
Lake Oswego, OR 97034

Release: I understand that this is a high-risk sport and I am participating at my own risk. I hereby release and hold harmless the organizer, organizing committee, judges and officials, the host and property owners from all liability for accidents, damage, injury or illness to horses, owners, riders, attendants, spectators, or any other person or property damage suffered during or in connection with this event. (*Parent or guardian must sign if competitor is under 18.*)

Signature \_\_\_\_\_ Address \_\_\_\_\_

Name (print) \_\_\_\_\_ City, State, ZIP \_\_\_\_\_

Phone # \_\_\_\_\_ E-mail \_\_\_\_\_

We need volunteers! If you or a person with you can help, please fill in the following:

Name: \_\_\_\_\_ Telephone: \_\_\_\_\_

Scribe     Jump Judge     Gate     Runner     Food     Other: \_\_\_\_\_

***THANK YOU!***

**EMERGENCY MEDICAL RELEASE FORM**

*(Completion of this form is mandatory if competitor is under 18 years of age.)*

If emergency care is required for \_\_\_\_\_ in conjunction with the Lake Oswego Hunt Horse Trials and if normal permission is not available in a timely manner, the undersigned authorizes appropriate emergency medical care as deemed necessary by emergency medical personnel, a physician or the medical facility providing treatment.

**Related information:**

Parent or Guardian \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

If parent or guardian is not available contact \_\_\_\_\_

Family Physician \_\_\_\_\_

Competitor is allergic to \_\_\_\_\_

Competitor is taking the following medication \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_