ACKNOWLEDGMENT OF RISK, WAIVER& RELEASE HORSE - ADULT
(THIS FORM MUST BE COMPLETED BY ALL PARTICIPANTS 18 YEARS & OLDER)

I, ____ the undersigned hereby apply to participate in the **TRAIL RIDE** to be conducted in cooperation with Cornell Cooperative Extension Association of County and acknowledge as follows:

I fully understand and acknowledge that there are inherent risks and dangers in my participation in the above activities and my participation in said activities and use of any equipment or materials related to such activities may result in my injury, illness or death and damage to or loss of my personal property. I understand other participants, accidents, forces of nature or other causes may cause these risk and dangers and I hereby fully acknowledge and accept these risk and dangers.

I am in good health and I am at or above the minimum age of 18 required to participate in this activity and I am able to participate in any strenuous physical activity associated therewith.

I herewith release, forever discharge and waive any right of recovery or subrogation against Cornell Cooperative Extension, its officers, directors, employees and volunteers from any and all liability whatsoever for any illness or injury, including death or damage to or loss of my personal property that I may sustain while I am participating in this program. This shall be binding on my heirs, successors, assigns, administrators and executors. Any claims or disputes arising out of my participation in the activity shall first be submitted to arbitration and/or be venued in the Supreme Court of the State of New York of the sponsoring County Association, the choice of which shall be at the sole discretion of CCE.

I HAVE READ THE ABOVE OR I ACKNOWLEDGE, IF VERIFIED BELOW BY THE INSTRUCTOR, THAT I HAVE HAD THIS DOCUMENT READ TO ME AT MY REQUEST AND BY SIGNING IT I AGREE IT IS MY INTENTION TO PARTICIPATE IN THE INDICATED ACTIVITY AND I UNDERSTAND AN ACCEPT ALL THE RISKS INVOLVED.

DATE OF TRAIL RIDE: October 4, 2015

LOCATION OF TRAIL RIDE: Bob's Trees, 1227 West Galway Rd., Galway, NY

PARTICIPANT'S FULL NAME (print) ____

DATE OF BIRTH: __________________

ADDRESS: ____

SIGNATURE: ______________________________ **DATE:** __________________

WITNESS: ______________________ **SIGNATURE:** ______________________

(MUST BE CCE EMPLOYEE OR 4-H VOLUNTEER)

This form must be kept in CCE Association files for seven (7) years from date of show.