

# APPLICATION FORM FOR RIDERS AND CARRIAGE DRIVERS

PLEASE USE BLOCK CAPITALS AND RETURN TO ADDRESS BELOW

2a(9)(a)



<b>GROUP NAME</b>	
<b>CHARITY NO</b>	
<b>NAME</b>	
<b>ADDRESS</b>	
<b>TEL NO</b>	

**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
	Would weight-bearing be a problem ?	Yes	No
Riding/Carrriage Driving	Do you have any previous experience with an RDA Group ?	Yes	No
	If YES, have you passed any proficiency tests ?	Yes	No
<b>Please give any other information that you think would be useful</b>			

**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)**

<p>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.</p>	
Do you agree that photographs/videos taken during Group activities may be used for training/publicity?	
Date	
Signature	Rider/Carriage Driver/Parent/Guardian (Delete as appropriate)

Riding for the Disabled Association Incorporating Carriage Driving (RDA)  
 Registered Company Number 5010395 Registered Charity No 244108 (England & Wales) No SC039473 (Scotland)  
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