



NSBA Equestrians With Disabilities Special Diagnosis Form

National Snaffle Bit Association
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Gurnee, IL 60031 (847)623-6722
Fax (847)625-7435
www.nsba.com

PLEASE NOTE: According to official NSBA rules and regulations, participants in the equestrians with disabilities competition must be 8 years of age and over with a diagnosed mental or physical condition attest to by a licensed medical physician. This form must be completed, signed by a licensed medical doctor and submitted to NSBA prior to competing in approved classes for Equestrians With Disabilities.

Name _____

NSBA ID # _____

Address _____

City _____

State/Province/Country _____

Zip/Postal Code _____

Day Telephone (____) _____

E-mail _____

Eligible Conditions

From the list below, please indicate each condition which applies to the applicant. Other conditions will be considered upon request (please list in space provided).

- | | | |
|---|---|--|
| <input type="checkbox"/> Amputation | <input type="checkbox"/> Arthrogryposis | <input type="checkbox"/> Asperger's Syndrome |
| <input type="checkbox"/> Autism | <input type="checkbox"/> Batten's Disease | <input type="checkbox"/> Cerebrovascular Accident (stroke) |
| <input type="checkbox"/> Cerebella Ataxia | <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Coffin Lowry Syndrome |
| <input type="checkbox"/> Cystic Fibrosis | <input type="checkbox"/> Down Syndrome | <input type="checkbox"/> Dwarfism |
| <input type="checkbox"/> Fragile X Syndrome | <input type="checkbox"/> Freidrick's Ataxia | <input type="checkbox"/> Guillan Barre Syndrome |
| <input type="checkbox"/> Hearing Impairment | <input type="checkbox"/> Hunter's Syndrome | <input type="checkbox"/> Juvenile Rheumatoid Arthritis |
| <input type="checkbox"/> Cognitive Disabilities | <input type="checkbox"/> Microcephaly | <input type="checkbox"/> Multiple Sclerosis |
| <input type="checkbox"/> Muscular Dystrophy | <input type="checkbox"/> Post Polio Syndrome | <input type="checkbox"/> Prader Willie Syndrome |
| <input type="checkbox"/> Rhett Syndrome | <input type="checkbox"/> Spina Bifida | <input type="checkbox"/> Spinal Cord Injury |
| <input type="checkbox"/> Tourettes Syndrome | <input type="checkbox"/> Traumatic Brain Injury | <input type="checkbox"/> Trisomy Abnormalities |
| <input type="checkbox"/> Visual Impairments | <input type="checkbox"/> Other _____ | |
- (subject to approval)

Medical Statement

In accordance with NSBA Rules, this applicant has been diagnosed with the above designated condition(s).

Name of Physician _____ Date _____

Signature of Physician _____ License _____

City and State/Province/County of Practice _____

PLEASE NOTE: According to NSBA Rules and Regulations, each participant or their parent/guardian by allowing participation, assumes all risk of personal injury or property damage occurring as a result of the participation and does hereby release and discharge the NSBA and show management, their respective officers, directors, representatives, and employees from any and all liability, whenever or however arising, from such participation, except for the negligent act or omission, if any, of an indemnities. Further, as parent or legal guardian, they agree to indemnity and hold harmless NSBA and show management from such liability to the minor.

Signature of participant or parent/guardian (if under 18)

Date