



**NSBA Equestrians With Disabilities
Special Diagnosis Form**

National Snaffle Bit Association
120 Mesa St
Weatherford, TX 76086
(847)623-6722
www.nsba.com
Email form to: office@nsba.com

PLEASE NOTE: According to official NSBA rules and regulations, participants in the equestrians with disabilities competition 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 _____
Independent Supported Date of Birth _____

Contact / Guardian Name _____
Change in condition?
Please Explain: _____

Eligible Conditions

From the list below, please indicate each condition which applies to the applicant. Other conditions will be considered upon request (please use space provided) ****All Statements are confidential****

- | | | |
|---|---|--|
| <input type="checkbox"/> Amputation | <input type="checkbox"/> Arthrogyrosis | <input type="checkbox"/> Cerebrovascular Accident (Stroke) |
| <input type="checkbox"/> Autism | <input type="checkbox"/> Batten's Disease | <input type="checkbox"/> Coffin Lowry Syndrome |
| <input type="checkbox"/> Cerebella Ataxia | <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Dwarfism |
| <input type="checkbox"/> Cystic Fibrosis | <input type="checkbox"/> Down Syndrome | <input type="checkbox"/> Guillain Barre Syndrome |
| <input type="checkbox"/> Fragile X Syndrome | <input type="checkbox"/> Friedreich's Ataxia | <input type="checkbox"/> Juvenile Rheumatoid Arthritis |
| <input type="checkbox"/> Microcephaly | <input type="checkbox"/> Hunter's Syndrome | <input type="checkbox"/> Muscular Dystrophy |
| <input type="checkbox"/> Post-Polio Syndrome | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Rhett Syndrome |
| <input type="checkbox"/> Spina Bifida | <input type="checkbox"/> Prader Willie Syndrome | <input type="checkbox"/> Trisomy Abnormalities |
| <input type="checkbox"/> Traumatic Brain Injury | <input type="checkbox"/> Spinal Cord Injury | |

Cognitive Disabilities: _____ Hearing Impairments _____
Other: _____ Visual Impairments _____

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.