NSBA Equestrians With Disabilities
Special Diagnosis Form

National Snaffle Bit Association
1391 St. Paul Ave
Gurnee, IL 60031
(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****

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

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.

______________________________ ____________________

Printed Name of Guardian or parent Signature of participant / parent / guardian Date