

EQUESTRIAN ZONE

Medical History & Emergency Contact Information

Participant: _____ Rider Volunteer Staff
DOB: ___/___/___ SSN: _____ Age: _____ Height: _____ Weight: _____ Gender: M F
Address: _____ City: _____, State: _____ Zip: _____
Phone: _____ Alternative #: _____ Mobile: _____
Employer/School: _____ Email: _____
Phone: _____ Alternative #: _____ Mobile: _____

In case of an emergency, the following person(s) is authorized to act on my behalf:

Emergency contact: _____ Relationship: _____ Telephone: _____
Emergency contact: _____ Relationship: _____ Telephone: _____

Physician Name: _____ Telephone: _____
Hospital Preference: _____ Insurance: _____

Are there any known allergies (such as animal, insect, etc.) and/or health conditions (asthma, heart, high blood pressure, seizures, etc.) that might be affected by participation in activities at Everything Equestrian? **Y N** If yes, please specify: _____

Do you have any physical and/or mental health conditions, problems and/or disabilities which may affect your ability to safely ride a horse or participate in the activities for which you have completed this form? **Y N** If yes, please specify (a statement from your physician may be required). _____

MEDICATIONS (include prescription & over-the-counter: name, dose, & frequency and reason for taking: _____

Has your physician or any treating specialist expressed concerns about riding or being near horses? **Y N** If yes, please attach a statement from the physician allowing for participation in these activities.

In the event of an emergency, I _____ consent / _____ do not consent to be treated by a doctor or trained medical professional at the stables or at a clinic or hospital near Equestrian Zone.

I have completed the above information to the best of my knowledge and will assume the responsibility for my own health and safety during any activity associated with Equestrian Zone.

Signature: _____ **Date:** _____
Participant/Parent if child is a minor