Horse & Rider Connection
Thrive With Horses
Medical Information & Release

PARTICIPANT

Name: _____ Date of Birth: ____/____/_____ Male D Female D

Address: _____ City: _____ State: ___ Zip: _____

Home Phone: _____ Cell: _____ Email: _____

PARENT OR LEGAL GUARDIAN INFORMATION

Parent/Guardian Name: _____ Relationship: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell: _____ Work Phone: _____

Email: _____ Does participant live with you? Yes D No D

Parent/Guardian Name: _____ Relationship: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell: _____ Work Phone: _____

Email: _____ Does participant live with you? Yes D No D

In case parent(s}/legal guardian cannot be reached in an emergency, contact:

Name: _____ Phone: _____ Relationship to Participant: _____

Name: _____ Phone: _____ Relationship to Participant: _____

In case of emergency, if family physician cannot be reached, I hereby authorize my child to be treated by Certified Emergency Personnel (i.e. EMT, First Responder, ER physician).

Signature: _____

Family Doctor: _____ Phone: _____

Address: _____ City: _____ State: _____

Hospital Preference: _____

Parent Insurance Carrier: _____ Policy No. _____ Group ID: _____

Please list any allergies and/or medical problems, include those requiring regular medication (ie Diabetes, Asthma, Seizure Disorder).

Medical Diagnosis	Medication	Dosage	Frequency of Dosage

Date of last Tetanus Toxoid Booster: _

The purpose of the above listed information is to ensure that medical personnel have details of any medical problem which may interfere with or alter treatment.

Authorized Parent/Guardian signature: _____ Date: _____