

SHARP EQUESTRIAN

PARTICIPANT HEALTH FORM

Note: In the unfortunate event you or your child should become sick or injured during one of our activities, the information on this form will expedite the proper care should you or your child need to be seen at a hospital. Please fill out completely. Each participant needs his/her own form. **Do not list multiple participants on one form!**

Health Insurance:

Participant Name: _____ Gender: Male Female

Age: _____ Birth Date: ____ / ____ / ____ Social Security Number: ____ - ____ - ____ (For care provider)

Address: _____
Street Address City State Zip

Day Phone: (____) _____ Eve Phone: (____) _____

Cell Phone: (____) _____ Email: _____

If Participant Under 18:

Father's SSN: ____ - ____ - ____ Mother's SSN: ____ - ____ - ____

Parent/Legal Guardian: _____
First Last

↓ Parent/Legal Guardian's Address:

Street Address City State Zip

Day Phone: (____) _____ Eve Phone: (____) _____

Cell Phone: (____) _____

2nd Parent/Legal Guardian: _____ Relationship: _____
First Last

↓ Second Parent/Legal Guardian's Address:

Street Address City State Zip

Day Phone: (____) _____ Eve Phone: (____) _____

Cell Phone: (____) _____

Emergency Contact:

Name: _____ Relationship: _____
First Last

Address: _____
Street Address City State Zip

Day Phone: (____) _____ Eve Phone: (____) _____

Cell Phone: (____) _____

A copy of the front and back of your medical insurance card must be attached to this form and returned to Sharp Equestrian. If your medical card is not attached and your child requires a visit to the hospital during his/her time in our program, the parent or legal guardian will be billed as private pay and will be responsible for the bill.

(Continued next page...)

Health History:

Is the participant listed above currently under medical supervision? Yes No

Explain: _____

Is the participant listed above currently taking any medications? Yes No

Explain: _____

Does the participant listed above have any known allergies to any types of food or medications? Yes No

Explain: _____

I hereby give permission to the medical personnel attending to the treatment of me/my child to order x-rays, routine tests and treatment for me/my child, and, in the event I cannot be reached in an emergency, I hereby give permission to the attending physician to hospitalize, secure proper treatment for, and to order injection and/or anesthesia and/or surgery for my child as named above. I give permission to the Sharp Equestrian personnel to arrange for necessary related transportation for me/my child.

Signature of Parent/Legal Guardian: _____ Date: ____ / ____ / ____

Signature of Witness (Required): _____ Date: ____ / ____ / ____