

Windmill Stables

MEDICAL HISTORY AND RELEASE (To be completed in full by each Rider and Handler)

Information below is intended solely for *Huf Stables, LLC (dba Windmill Stables)* use in aiding the rendering of appropriate emergency care. It is not used as a device for the screening of riders and handlers.

Name: _____ DOB: _____ Gender: M / F

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

Email address: _____ Phone #: _____

Guardian's Name (if under 18 years): _____

Email address: _____ Phone #: _____

Have you had any spinal or coronary injuries or defects or been diagnosed as having an arthritic condition

Yes No If "YES", give details: _____

Date of most recent tetanus inoculation (state, "none" if applicable): _____

Are you allergic to any medication? Yes No

If "YES", indicate all known allergens: _____

Have you ever been advised by a doctor not to participate in equestrian sports? Yes No

If "Yes", give details: _____

Do you have any condition or handicap that might impair your ability to participate in any equestrian sport?

Yes No If "Yes", give details: _____

IN CASE OF EMERGENCY CONTACT:

Name: _____ Relation: _____

Email address: _____ Phone #: _____

In case of a medical emergency, it is my understanding that first aid will be administered, if deemed necessary. Should the situation prove to be more serious and first aid is not sufficient treatment, it is my understanding that my child or I will be transported to the nearest emergency facility, or if possible, the medical facility listed above, and I authorize this facility to provide medical or surgical procedures necessary to preserve the life or well being of the above named participant.

AUTHORIZATION FOR EMERGENCY MEDICAL ATTENTION: In the event a parent cannot be reached to make emergency medical arrangements, I authorize Windmill Stables staff to take my child to:

Physician Name: _____ Phone #: _____

Address: _____ Hospital: _____

Is Rider / Handler covered by medical insurance? Yes No

If yes, Insurance Name _____ Policy Holder's Name _____

Billing Address _____ Group # _____ Policy # _____

Signature: _____ Date: _____

Signature of Guardian (if under 18 years): _____ Date: _____