

TRAIL RIDE PARTICIPANT HEALTH FORM

(Your Trail Ride Name Here)

The purpose of this form is to provide the _____ Trail Ride management with your health information in the event of a medical emergency. Please complete a separate form for each rider. Make copies of the form as needed for multiple riders in your party. Your health information is confidential.

Name _____ Age _____
(Last Name, First) (If under 18)

Address _____

City _____ State _____ Zip _____

Telephone _____
(daytime) (evening) (cell)

E-Mail _____

Signature of legal guardian, if participant is under 18 years of age.

Guardian Name _____

Guardian Signature _____

Telephone _____
(daytime) (evening) (cell)

In case of emergency, please contact _____
Telephone Number _____

Do you smoke? ___Yes ___No

Are you taking any medications? ___Yes ___No

If yes, what is the name(s) of the medication(s)?

1. _____
2. _____
3. _____

Do you have any allergies? ___Yes ___No

If yes, please list your allergies.

1. _____
2. _____
3. _____

Are you diabetic? ___Yes ___No

If yes, do you depend on insulin? ___Yes ___No

Do you suffer from: ___Arthritis ___Asthma ___Rheumatism ___Emphysema ___Tendonitis ___Chronic
___Bronchitis ___Other _____

Do you have high blood pressure? ___Yes ___No

Have you ever had surgery? ___Yes ___No

If yes, what type of surgery? _____

Are you pregnant, or is there a possibility that you might be pregnant? ___Yes ___No

If yes, when is your due date? _____