

Health History and Emergency Medical Authorization Form

Name (Last, First, Middle) _____

Birth Date _____

Pertinent Health History:

<input type="checkbox"/> ADD/ADHD	<input type="checkbox"/> Epilepsy	Allergies:
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Fainting	<input type="checkbox"/> Animals _____
<input type="checkbox"/> Asthma	<input type="checkbox"/> Hay Fever	<input type="checkbox"/> Bee/wasp stings _____
<input type="checkbox"/> Headaches/Migraines	<input type="checkbox"/> Skin Conditions	<input type="checkbox"/> Drugs _____
<input type="checkbox"/> Bleeding/clotting disorders	<input type="checkbox"/> Hearing Problems	<input type="checkbox"/> Food _____
<input type="checkbox"/> Heart Defect/disease	<input type="checkbox"/> Frequent Colds/Sore Throats	<input type="checkbox"/> Other _____
<input type="checkbox"/> Wears: <input type="checkbox"/> Contacts <input type="checkbox"/> Glasses	<input type="checkbox"/> Muscle disease/disorder	
<input type="checkbox"/> Hypertension	<input type="checkbox"/> Diabetes	
<input type="checkbox"/> Seizures	<input type="checkbox"/> Other: _____	

Pre-existing Condition Information

To help us provide and arrange for the best treatment available in case of an accident, please help us by answering the following questions. We respect your privacy and understand the sensitive nature of the information being requested. We will never share this information with anyone other than the Academy Trainers, Management Team, Emergency Response Personnel, and Emergency Room Physicians. Please indicate if the participant currently has, or has suffered from any of the following conditions:

C = Current (within last 12 months)

P = Past

N = N/A

Has the participant ever had:	C	P	N		C	P	N
Complete/partial hearing loss				Seizures			
Head injury				Palpitations (heart)			
Heat related illness				Heart murmur			
Orthopedic injury				Chest pains with or w/out exercise			
Dizziness or Fainting				Bleeding Disorder (Hemophilia)			
Shortness of breath or Asthma				Stroke			
Been told not to participate in sports?				High Blood Pressure			
Allergies or Anaphylactic Shock				Diabetes			

If you answered "yes" to any of the above, please explain: _____

Does participant have any type of medication that they would like us to keep and administer in the case of emergency? Yes No

If yes, please indicate type: _____ and see the Head Trainer so appropriate arrangements can be made.

Any special needs or accommodations required? _____

Are there any known behavioral and /or emotional problems? _____

Ever required psychiatric counseling or hospitalization? _____

Operations or serious injuries _____

Disability or chronic or recurring illness _____

Activities encouraged or limited by your physician? _____

Immunization Information:

For information only, please attach a copy of you or your child's immunization record.

Insurance Company _____ Policy Number _____ Group ID _____

Primary Physician Name, Number & Contact Instructions: _____

Name & Phone of PCP: _____ Relationship to Participant: _____

My child may be given:

Aspirin Benadryl Neosporin Tylenol Sunscreen Other: _____ None

****MEDICAL AUTHORIZATIONS AND EMERGENCY RELEASE****

European Sport Horses of American, Inc. and its representatives have my permission, in an emergency when I cannot be located immediately, to provide emergency medical attention and, if necessary, to transport my child to the emergency room of the nearest hospital, at my expense. The hospital and its medical staff have my authorization to provide treatment which is deemed necessary for the well-being of my child. This health history is correct as far as I know. The person herein described has permission to engage in all activities except as noted. I hereby give permission to the First Responder or Adult-in-Charge to provide routine health care and administer prescribed medications as indicated on this form. I consent for my child to receive such medical treatment and/or surgical procedures as are deemed necessary in the event of an emergency and to assume liability for any medical expenses involved. This authorization extends to my child's participation in any activity sponsored by American Academy of Equestrian Sciences. Should a medical emergency arise during my child's participation in any given activity, I understand that reasonable efforts will be made to contact me or my designed alternate at the phone numbers I have given. If it is believed my child's life or health may be adversely affected by the delay that an attempt to contact me or my designated alternate would cause, I consent to the administration of medical treatment and/or surgical procedure deemed necessary by the medical doctor and/or medical facility and the immediate administration of life-sustaining measures deemed necessary under the circumstances. This completed form may be photocopied for trips outside of the normal meeting place.

Signature of Parent/Guardian _____ Date: _____