



EMERGENCY CONTACT AND CURRENT MEDICAL INFORMATION

PARTICIPANT INFORMATION					
Name:		Date:		Date of Birth:	
Home Address: Mailing Address:				Home: Cell:	
Parent Name:			Home:		Cel:
Parent Name:			Home:		Cel:

Physician(s):	Physician's Phone Number:	Dentist(s):	Dentist's Number:

EMERGENCY CONTACTS IN CASE PARENTS CANNOT BE REACHED				
NAME	RELATIONSHIP	HOME PHONE	MOBILE PHONE	WORK PHONE

MEDICAL CONDITIONS AND/OR ALLERGIES		
1.	2.	3.
4.	5.	6.

FOOD ALLERGIES	
FOOD	REACTION

Is the participant currently taking any medications? YES _____ No _____ If yes please explain and advise if medication is to be taken during camp hours _____

Is the participant experiencing any current health problem, under medical care, or receiving mental or behavioral services? YES _____ No _____

Has the participant undergone surgery or experienced an injury, illness, allergy or change in health status at any time during the last year? YES _____ No _____

Are your child's immunizations up to date? YES _____ No _____

Is there any reason that participation in social, educational, athletic, or any other event, especially Horseback Riding sponsored at or around Trinity Ranch Inc.'s facilities should be restricted in any way? Yes _____ No _____

If Yes, Please explain _____

CONSENT PLAN

In the event of medical aid/treatment is required due to illness or injury during the participants attendance at camp, I authorize TRINITY RANCH, INC. to:

Secure and Retain Medical Treatment and Transportation if needed.

Release participant's records upon request to authorized individual or agency involved in the medical emergency treatment.

This consent includes but is not limited to x-ray, surgery, hospitalization, medication and any treatment or procedure deemed "life saving" by the authorized individual or agency.

THIS PROVISION WILL BE INVOKED ONLY IF ANY OF THE EMERGENCY CONTACTS LISTED ABOVE CANNOT BE REACHED

Date _____ Consent Signature _____

Witness Name _____ Signature _____