HORSES WITH A MISSION, INC.

A LICENCED SPIRITHORSE THERAPEUTIC RIDING CENTER

Contact Information and Medical History

Date: _____ { } Client { } Staff { } Volunteer { } Parent or Legal Guardian { } Caregiver { } Sibling

CONTACT INFORMATION:

Name: _____ DOB: _____

If applicable please indicate affiliated rider:_____

Parent/Legal Guardian/Caregiver:_____

Address:_____

City:_____ State:_____ Zip:_____

Email:_____

Home Phone:_____ Cell Phone:_____ Work Phone:_____

Employer:_____ School:_____

Medical Information:

Weight:_____ Height:_____ M F

History:_____

Allergies:_____

Current Medications:_____

Medical Conditions:_____

Physician's Name :_____Physician's Phone Number:_____ Fax:_____

Health Insurance Co.:_____ Policy #:_____

In the event of an emergency, contact:

Primary Contact:_____ Relation:_____ Phone:_____

Secondary Contact:_____ Relation:_____ Phone:_____

Third Contact:_____ Relation:_____ Phone:_____