

Heavenward Farm and Horsemanship

Morrow, OH

(513)265-4477

Medical Information and Authorization

Participant Name: _____ D.O.B. _____

Address: _____

(Street)

(City, State)

(Zip Code)

Medical Conditions/Allergies: _____

Medications Taken (for. . .): _____

Limitations on Physical Activity: _____

Behavioral or Emotional Issues (fears, reactions, etc) _____

Emergency Contacts: (Please Print Neatly)

Name: _____ Tel. # (____) _____

Relationship: _____ 2nd Tel. # (____) _____

Name: _____ Tel. # (____) _____

Relationship: _____ 2nd Tel. # (____) _____

Physician: _____ Phone: (____) _____

Preferred Medical Facility: _____

I hereby authorize first aid measures to be administered by the program director and/or volunteers, and for the director to make decisions as to further treatment to be sought. Any treatments or remedies known to cause an adverse reaction in the participant are listed on this page. In the event that I, or an emergency contact person, can not be reached, I authorize my physician to make emergency health care decisions on my behalf. The term "health care" as used in this form shall have the meaning set forth in the Ohio Revised Code Sections 1337.11 - 1337.17.

Signature: _____ **Date:** _____

Name (Print): _____ **Phone:** _____

Relationship: _____ **Address** _____