APPENDIX 4B-RR1

Michigan 4-H Proud Equestrians Program
Rider Registration and Emergency Treatment Form

This form is valid for a period of one year from the date signed.

No individual can be accepted for riding instruction in a Michigan 4-H Proud Equestrians Program until this form has been completed by his/her parent(s)/guardian or by the individual if he/she is a legally competent adult 18 years of age or over.

Date__________________________ ❑ New Rider ❑ Return Rider School Attending ______________________________

Rider: Full Name ____ Date of Birth______________________

Mailing Address____

City ____ State ______________ Zip__________________

Phone (_______)___________________

Diagnosis____ Date of Onset _____________

Age_____________ Height ______________ Weight __________________

Previous Riding Experience ____

Parent/Guardian: Full Name:____ Phone (_______)_______________

Mailing Address____

City ____ State ______________ Zip__________________

Physician: Name ____ Phone (______)________________

Address ____

City ____ State ______________ Zip__________________

Person who should be notified in case of emergency in absence of parent/guardian:

Name____ Phone (______)_______________

Relationship to Rider____

AUTHORIZATION FOR PURPOSE OF PROVIDING MEDICAL TREATMENT

You are being asked to complete this form to give an appropriate medical facility permission to treat ______________________ ____________________________(rider's name) for minor injury or medical problems. In the event of serious injury or illness, you will be contacted; treatment will proceed before contacting you only if the situation is urgent and does not permit delay.

Preferred Medical Facility ____

Is there a medical condition, allergy, etc., requiring special precaution or treatment? ❑ Yes ❑ No

If Yes, please describe:____

Medications currently being used? ❑ Yes ❑ No If Yes, please list name, purpose and dosage: ________________

____

In case of medical emergency: The undersigned authorizes the Michigan 4-H Proud Equestrians Program instructor and/or program coordinator to seek any medical and/or surgical treatment necessary for the care of ___________________________ who is participating in the Michigan 4-H Proud Equestrians Program with parent/guardian permission and with the permission of his/her physician (name)____.

HEALTH INSURANCE

Name of Policyholder/Relationship to Participant:____

Policyholder's address____

Please attach a photocopy of both sides of your insurance card (preferred) OR complete the insurance information requested here.

Name and Address of Insurance Company____

Insurance Company Phone Number (______)________________ **Policy Number**______________________________

Name of Policyholder's Employer____

REQUIRED SIGNATURES

The above designated person(s) is(are) hereby authorized to incur medical costs necessary to provide medical treatment for said participant for which we shall be fully responsible. We also authorize the medical facility to release any and all information required to complete insurance claims and also authorize insurance payment directly to the medical facility.

Signature: ____ **Date:**____________________

Parent(s) / Guardian / Adult Rider (Circle appropriate title)

Witness:____

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