MEDICAL FORM

GREAAT! Gainesville Riding through Equine Assisted Activities and Therapy

Student Name_____

Parent(s) or Guardian(s)_____

Address_____

City_____State_____zip_____

Phone Number_____

Rider's Disability (if any)_____

Date of onset_____Date of birth_____

Physician's Name_____

Phone #_____

Health Insurance Co._____Policy #_____

Person who is authorized to give temporary assistance or care in absence

of parent or guardian:_____
name relationship phone

Preferred Medical Facility:_____

Describe any medical condition requiring precautions or treatment and any medications and dosage

_____

_____

_____
Signature