



**RIDER EMERGENCY INFORMATION**

**Rider Information:**

Name: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Birth Date: \_\_\_\_\_

Daytime Phone: \_\_\_\_\_

Evening Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

**Emergency contact in case of injury or illness to owner/rider:**

Name: \_\_\_\_\_

Relationship to Rider: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

**Rider's Medical Information:**

Personal Physician: \_\_\_\_\_

Hospital Affiliation: \_\_\_\_\_

Phone: \_\_\_\_\_

Date of last Tetanus shot: \_\_\_\_\_

Blood Type: \_\_\_\_\_

Existing Medical Conditions \_\_\_\_\_  
\_\_\_\_\_

Allergies / Sensitivities \_\_\_\_\_  
\_\_\_\_\_

Regular Medications: \_\_\_\_\_  
\_\_\_\_\_

Notable Injuries: \_\_\_\_\_  
\_\_\_\_\_

**Health Insurance**

**Carrier:** \_\_\_\_\_

Plan / Policy Number: \_\_\_\_\_

Phone Number: \_\_\_\_\_

**Consent to Treatment:**

In the event that I am injured or become ill and am not conscious or otherwise capable of making an informed decision regarding medical care, I hereby consent to such emergency medical treatment as is deemed necessary and prudent by a licensed medical professional until such time as I regain consciousness or until the contact person designated above can be reached and consent to or decline treatment on my behalf.

Signed: \_\_\_\_\_

Date: \_\_\_\_\_

Please update yearly or after any injury.

**HORSE EMERGENCY INFORMATION**

**Veterinarian Information:**

Name: \_\_\_\_\_

Phone: \_\_\_\_\_

**Insurance Information:**

**Carrier:** \_\_\_\_\_

Plan / Policy Number: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Horse Owner's Contact Info (if different from riders)

Name: \_\_\_\_\_

Phone: \_\_\_\_\_

**Veterinarian Expenses Cap:**

Dollar Amount: \_\_\_\_\_

Special Instructions: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Consent to Treatment:**

In the event that I am injured or become ill and am not conscious or otherwise capable of making an informed decision regarding horse's medical care, I hereby consent to such emergency medical treatment, not to exceed the veterinarian expense cap, as is deemed necessary and prudent by a licensed medical professional until such time as I regain consciousness or until the contact person designated or the horse owner can be reached and consent to or decline treatment on my behalf.

Signed: \_\_\_\_\_

Date: \_\_\_\_\_