

Tri-State Riding Club
MEMBER Medical Information Form

MEMBER INFORMATION:

Last Name: _____ First Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Emergency contact person: (1) _____ (name)

contacts phone numbers: _____ home
_____ work
_____ cell

(2) _____ (name)

contacts phone numbers: _____ home
_____ work
_____ cell

Member's physician name: _____

Member's physician phone: _____

Member's allergies: _____

Pertinent Medical condition(s): _____

Current Medical Insurance Company: _____

Insurance Policy Number: _____

Special Instructions in case of emergency: _____

Member signature

Date of signature

1. *This medical release should be updated upon any changes of the above information.*
2. *TSRC recommends that members carry a signed copy of this form on their person and in their medical armband at all mounted activities.*
3. *A copy of personal insurance card may be attached to this form.*