

**Horse Council BC  
Medical Information Form**

**The information on this form will be used to ensure prompt, effective attention in the case of a medical emergency. This confidential information will be sent back to the HCBC office and destroyed after the evaluation/examination.**

Name of Participant: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell phone: \_\_\_\_\_

Emergency contact name(s): \_\_\_\_\_

Emergency contact phone (cell and home number) \_\_\_\_\_

Family Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Medical Conditions: (if any)

Please list all known Allergies: (please note if you have an EPI pen and where you keep it)

Any other relevant information (ie: pregnancy, epilepsy etc) or if you have any injuries or illness' at this time:

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