

CONFIDENTIAL

SHELTOWEE TRAIL RIDE

Your Name: _____

MEDICAL INFORMATION AND PERMISSION TO TREAT

This information is strictly confidential. It is provided to the Ride Physician and is used only in case of emergency.

The Ride Physician has full authority to prohibit an applicant from participating in the Sheltonwee ride if participant is deemed unfit for medical reasons and/or is disabled by certain physical impairments.

(Please print clearly. Thank you!) Your Age _____ Sex: ___M or ___ F

Will you be attending by yourself? ___ Yes ___ No

If NO, with whom will you be attending? _____

Please list any medical conditions: _____

Please list any allergies or allergic reactions you may have to medications: _____

Please list all medications you are currently taking: _____

In case of emergency, please contact: (Name, relationship, and phone number)

1st _____

2nd _____

If you have any special needs or concerns, please discuss them with the ride physician.

PERMISSION TO TREAT

In the event of medical necessity, it is my desire that the Ride Physician initiate any medical treatment he or she deems necessary for my well-being. I accept full responsibility for all medical and health care rendered in response to this letter of Permission to Treat. I will not hold the Sheltonwee ride managers or the Ride Physician, his/her heirs, heirs of his/her estate or assigns liable for any treatment rendered. Furthermore, in the event I refuse treatment offered, I agree to assume all risks and hold harmless the Ride Physician for any liability that may result from said refusal.

Participant Signature (Required) _____

(Your typed name is the same as your signature)

If participant is under age 18, parent or guardian must sign: _____

(Your typed name is the same as your signature)