

Name of GP:.....

GP Address:.....

Postcode:.....

Tel No:.....

**NEXT OF KIN**

Name:.....

Relationship to cardholder.....

Address:.....

Postcode:.....

Tel No:.....

**HORSEBOX DETAILS**

Make:.....

Colour:.....Registration.....

**EQUESTRIAN MEDICAL CARD**

Valid for the #SupportingTheSupporters Sponsored Ride Only

**PLEASE COMPLETE ALL SECTIONS**

Any rider who has a fall should be checked by a member of the medical team before continuing. The medical official may suspend the rider on medical grounds if in their view the rider should not continue

First Name :.....

Surname:.....

Date of Birth:.....Age.....

Religion:.....

Address:.....

Postcode:.....

Tel No:.....

**PREVIOUS MEDICAL HISTORY**

Previous Injuries	Yes	No	Specify with dates
Head			
Concussion			
Face			
Neck			
Back			
Chest			
Abdomen			
Limbs			

Previous Surgical Operation(s): YES / NO

If yes, specify with date(s).....

Medical Conditions	Yes	No	Current Medication
Diabetes			
Epilepsy			
Blackouts			
Asthma			
Heart			
Lung			
Kidney			
Other			

**MEDICAL CONDITIONS CONTINUED**

Medical Conditions	Yes	No	Specify with details
Do you have normal pupils?			
Do you wear contact lenses?			
Do you have normal hearing?			
Do you have any allergies?			
Are you on any medication?			
Are you on Cortisone (steroid)?			
Have you ever required Cortisone treatment?			

Blood Group:.....

Date of last tetanus immunisation.....

Any other relevant information.....