**Date completed:**

**PERSONAL DETAILS CONTACT DETAILS**

|  |  |  |  |
| --- | --- | --- | --- |
| Riders name in full: |  | Name of your own Doctor: |  |
| Riders body weight: |  | Address of Doctor: |  |
| Riders permanent address: |  | Telephone No. of doctor  (include area codes) |  |
| Riders D.O.B. |  | Name: (Next of kin) |  |
| Home Telephone: |  | Relationship: |  |
| MOB telephone Number: |  | Address: |  |
| Horse float/truck detailsMake: |  | Telephone number: |  |
| Colour; |  | Name of 2nd Contact:  You Must provide 2 contacts |  |
| Registration number: |  | Telephone number: |  |

PREVIOUS MEDICAL HISTORY PLEASE RECORD ALL DETAILS

|  |  |  |  |
| --- | --- | --- | --- |
| **Previous injuries** |  |  | INJURIES |
| Head |  |  |  |
| Concussion |  |  |  |
| Face |  |  |  |
| Neck |  |  |  |
| Back |  |  |  |
| Abdomen |  |  |  |
| Limbs |  |  |  |
| **Previous surgical operations and/or**  **medical conditions** |  |  | OPERATIONS & MEDICAL CONDITIONS |
| Diabetes |  |  |  |
| Epilepsy |  |  |  |
| Blackouts |  |  |  |
| Asthma |  |  |  |
| Heart |  |  |  |
| Lung |  |  |  |
| Other (including, kidney) |  |  |  |
| **0ther information** |  |  | GIVE DETAILS OF ALL ALLERGIES |
| Normal sight |  |  |  |
| Normal pupils |  |  |  |
| Do you wear contact lenses |  |  |  |
| Normal hearing |  |  |  |
| Allergies |  |  |  |
| **Medication** |  |  | RECORD ALL CURRENT MEDICATION |
| Are you taking any medication? |  |  |  |
| Are you taking cortisone (steroids)? |  |  |  |
| Have you ever required cortisone |  |  |  |
| (Steroid treatment)? |  |  |  |
| What is your blood group? |  | |  |
| Date of last tetanus immunisation |  | |  |