OHIO INTERSCHOLASTIC HORSEMANSHIP ASSOCIATION

MEDICAL TREATMENT FORM

(Permit for Treatment of Child)

RIDER NAME:_____

BIRTH DATE:_____ AGE:_____

STREET ADDRESS:_____

CITY:_____ STATE:_____ ZIP:_____

MEDICATIONS:_____

ALLERGIES:_____

PAST MEDICAL CONDITIONS/HISTORY:_____

_____

PHYSICIAN NAME/PHONE:_____

PARENT/LEGAL GUARDIAN: INITIAL HERE TO VERIFY RIDER IS COVERED UNDER A VALID MEDICAL INSURANCE POLICY. _____

PARENT/LEGAL GUARDIAN NAME:_____

STREET ADDRESS (IF DIFFERENT THAN RIDER) _____

CITY:_____ STATE:_____ ZIP:_____

HOME PHONE:_____ ALTERNATE PHONE:_____

EMERGENCY CONTACT:_____ PHONE:_____

EMERGENCY CONTACT:_____ PHONE:_____

COACH OR DESIGNEE NAME:_____

By signing this document, I/We, _____, the Parent(s) and/or Legal Guardian(s) of _____ authorize my child's coach or designee listed above to seek First Aid and Medical attention for my child. I also authorize the Ohio Interscholastic Horsemanship Association (OIHA) and/or its designees to seek First Aid and Medical attention for my child. In the event of an emergency, I authorize the licensed physician chosen by these designees to hospitalize, secure treatment, initiate anesthesia, and/or perform surgery for my child as is necessary.

PARENT/LEGAL GUARDIAN SIGNATURE:_____

PRINT NAME:_____

DATE:_____

Rev. 4/2017