

# EQUESTRIAN RIDER/MEDICAL RELEASE FORM

MUST BE FILLED OUT COMPLETELY OR IT WILL BE RETURNED

Submission Date: \_\_\_\_\_

A. Rider's Name \_\_\_\_\_ Home Phone: ( ) \_\_\_\_\_  
 Sex \_\_\_\_\_ Age \_\_\_\_\_ Date of Birth \_\_\_\_\_ Rider's Social Security # \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Solely to help us comply with government record keeping, reporting and other legal requirements, please check what applies:  
 White  African American  Hispanic  American Indian/Alaskan Native  Asian Pacific Islander  Other

B: Head of Delegation Mary Gwinner Delegation Code RID11  
 Home Phone ( ) \_\_\_\_\_ Work Phone (940) 479-2016  
 Street Address 9168 T. N. Skiles Road  
 City Ponder State TX Zip 76259

C: Parent or Guardian Name \_\_\_\_\_ Email \_\_\_\_\_  
 Home Phone ( ) \_\_\_\_\_ Work Phone ( ) \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

D: Person to Notify in Case of an Emergency ( ) Check here if it is the same as above  
 Name \_\_\_\_\_ Relationship to Rider \_\_\_\_\_  
 Home Phone ( ) \_\_\_\_\_ Work Phone ( ) \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

E: Name of Person Completing this Form \_\_\_\_\_

PHYSICAL EXAMINATION	Normal/Abnormal	Normal/Abnormal	Normal/Abnormal	Normal/Abnormal
Rider's height: _____	( ) Vision ( )	( ) Cardiovascular ( )	( ) Cranial nerves ( )	
Weight: _____	( ) Hearing ( )	( ) Respiratory ( )	( ) Coordination ( )	
Blood Pressure: _____/_____/_____	( ) Oral cavity ( )	( ) Gastrointestinal ( )	( ) Reflexes ( )	
	( ) Neck ( )	( ) Genitourinary ( )	( ) Extremities ( )	
	( ) Skin ( )			

1. Heart disease/heart defect/high blood pressure : ( )Yes ( )No Surgery required: ( )Yes ( )No
2. Chest pain or fainting spells ( )Yes ( )No
3. Seizures/Epilepsy : ( )Yes ( )No - Controlled ( )Yes ( )No - Date of last seizure \_\_\_\_\_
4. Diabetes ( )Yes ( )No
5. Down syndrome ( )Yes ( )No - Cervical spine x-rays ( )Yes ( )No - Date of last X-ray \_\_\_\_\_  
 Neurological symptoms of atlantoaxial instability: ( )Yes ( )No
6. Blindness/visual problem ( )Yes ( )No
7. Absence of one kidney or testicle ( )Yes ( )No
8. Concussion or serious head injury ( )Yes ( )No
9. Major surgery or serious illness ( )Yes ( )No
10. Heat exhaustion/stroke ( )Yes ( )No
11. Other problems that would interfere with equestrian participation: \_\_\_\_\_
12. Impaired motor ability ( )Yes ( )No
13. Wheelchair ( )Yes ( )No - Walker ( )Yes ( )No - Braces ( )Yes ( )No - Crutches ( )Yes ( )No
14. Allergic to the following  
 Medicines \_\_\_\_\_  
 Foods \_\_\_\_\_  
 Insect bites \_\_\_\_\_
15. Asthma ( )Yes ( )No Controlled ( )Yes ( )No
16. Tendency to bleed easily ( )Yes ( )No
17. Emotional problems/psychiatric disorder ( )Yes ( )No
18. Serious bone or joint disorder ( )Yes ( )No
19. Sickle cell trait or disease ( )Yes ( )No
20. Contact lenses/eyeglasses ( )Yes ( )No
21. Hearing aid/hearing loss ( )Yes ( )No
22. Immunizations up to date ( )Yes ( )No
23. Date of last tetanus: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Current Prescription Medication

Medication \_\_\_\_\_  
 Amount \_\_\_\_\_  
 Time of day \_\_\_\_\_  
 Medication \_\_\_\_\_  
 Amount \_\_\_\_\_  
 Time of day \_\_\_\_\_  
 Medication \_\_\_\_\_  
 Amount \_\_\_\_\_  
 Time of day \_\_\_\_\_  
 Medication \_\_\_\_\_  
 Amount \_\_\_\_\_  
 Time of day \_\_\_\_\_

**Notice to Physicians:** If the rider has Down Syndrome, Special Olympic Texas requires that the athlete have a full radiological examination establishing the absence of Atlantoaxial Instability before he/she may participate in equestrian events which, by their nature, may result in hyperextension, radial flexion or direct pressure on the neck or upper spine. X-rays positive for Atlantoaxial Instability exclude equestrian activities. By signing below, you have reviewed the above information and examined the rider named in the application, and certify there is not medical evidence that would preclude the rider's participation in Special Olympics Texas.

**WE MUST HAVE THE PHYSICIAN'S SIGNATURE - NO FAXED SIGNATURE, STAMPS OR PRACTITIONER SIGNATURES WILL BE ACCEPTED**

Physician's Name (Please print) \_\_\_\_\_ **Date** \_\_\_\_\_

**Physician's Signature** \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

## RIDER ENROLLMENT/MEDICAL RELEASE FORM – Page 2

Athlete Name \_\_\_\_\_

**Please note:** An up-to-date health history and a physical examination performed by a licensed physician is required upon entry into the program.

A physical examination is required every 3 years for Items 1-5

A physical examination is required for all athletes with a new problem to Items 6-10

Athletes must submit a medical release form every 3 years whether or not an examination is required.

Please provide name of rider's insurance company \_\_\_\_\_

Please provide insurance company's phone number \_\_\_\_\_

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It is understood and agreed that: if the examiner is provided free of charge, it is not intended to be a thorough or comprehensive examination. No physician-patient relationship is to arise out of examination. The doctor, nurse or other person involved in the examination is under no obligation to provide a diagnosis, treatment, advice, consultation or any follow-up care whatsoever under any circumstances. The fact that any person is cleared or authorized to participate in any sport or other activity does not mean and is not to be interpreted as the opinion of the doctor or nurse that the person examined is healthy, in need of no care, or can participate in any sport or other activity without serious medical risks. Any claim against the doctor, nurse or other person involved in the examination will be submitted to binding arbitration pursuant to the rules and procedures of the American Arbitration Association. The person examined and a person who signs on his or her behalf promises to indemnify the doctor or nurse from any and all damages, claims, or losses, including injury or death that allegedly arise out of or are in any way related to the examination.

Medical: I represent and warrant to you that the athlete is physically and mentally able to participate in Special Olympics Texas.

Disclaimer: On behalf of the athlete and myself, I acknowledge that the athlete will be using facilities at his/her own risk and I, on my own behalf, hereby release the physicians, organizers, officers, directors, agents or employees of Special Olympics Texas from any claim for damage or suit by reason of any injury, illness, or damage whatsoever to person or property of myself or the athlete.

Hospitalization: If I am not personally present at the even in which the athlete is to compete so as to be consulted in case of emergency, you are authorized on my behalf and at my account to take such measure and arrange for such medical and hospital treatment as you may deem advisable for the health and well-being of the athlete.

Media: In permitting the athlete to participate, I am specifically granting permission to you to use the name, likeness, voice and words of the athlete in television, radio, films, newspapers, magazines, web pages and other media, and in any form not heretofore described for the purpose of advertising or communicating the purposes and activities of Special Olympics Texas and in appealing for funds to support such activities.

**Check One:**      ( ) Parent                      ( ) Guardian                      ( ) Athlete (if over the age of 18)

**Parent/Guardian/Athlete Signature:** \_\_\_\_\_

Print Name of Above \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Please list sports in which athlete will compete: \_\_\_\_\_ EQUESTRIAN \_\_\_\_\_