



Horse Sense of the Carolinas, Inc.
Medical History, Emergency Information, & Health Care Consent

Client's Full Name: _____ Date of Birth: _____

Street Address, _____

City, State, Zip: _____

Phone(s): H: _____ W: _____ C: _____

Height: _____ Weight: _____ Tetanus Shot within the last 10 years: Y[] N[]

Medications & Dosage	Taken Since	Prescribed by (Physician)
_____	_____	_____
_____	_____	_____
_____	_____	_____

Allergies: (prescription drugs, foods, bee stings, etc.)	Reaction
_____	_____
_____	_____
_____	_____

Please check any areas of medical concern. If "yes," please explain in the Comments section

Areas	Yes	No	Comments
Auditory	<input type="checkbox"/>	<input type="checkbox"/>	_____
Visual	<input type="checkbox"/>	<input type="checkbox"/>	_____
Speech	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cardiac	<input type="checkbox"/>	<input type="checkbox"/>	_____
Circulatory	<input type="checkbox"/>	<input type="checkbox"/>	_____
Pulmonary	<input type="checkbox"/>	<input type="checkbox"/>	_____
Neurological	<input type="checkbox"/>	<input type="checkbox"/>	_____
Muscular	<input type="checkbox"/>	<input type="checkbox"/>	_____
Orthopedic	<input type="checkbox"/>	<input type="checkbox"/>	_____
Allergies / Asthma	<input type="checkbox"/>	<input type="checkbox"/>	_____
Learning Disability	<input type="checkbox"/>	<input type="checkbox"/>	_____
Psychological Impairment	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other _____	<input type="checkbox"/>	<input type="checkbox"/>	_____

By signing this form, I, _____ (please print parent/guardian/ adult client name) certify all information to be complete and true to the best of my knowledge.

Client's Signature: _____ Date: _____

Parent/Guardian's Signature (If client is minor): _____ Date: _____

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Parent/Guardian _____ Phone Numbers _____

* 1st Emergency Contact _____ Relationship to Client _____ Phone # _____

*2nd Emergency Contact _____ Relationship to Client _____ Phone # _____

*(*client's or parent/guardian's first choice for us to call if parent/guardian is unavailable in a medical emergency)*

Patient's Primary Physician _____ Phone Number _____

Preferred Medical Facility: _____

Emergency Medical Consent

The undersigned hereby grants to any *Horse Sense of the Carolinas Inc.* affiliate/employee/intern/volunteer the authority to receive information pertaining to the emergency health care of the client named below and to make emergency health care decisions with respect to the client if the undersigned is unavailable to obtain such information or make such decisions.

Client's Name _____ Phone: _____

Address: _____

Date: _____ Signature: _____

(parent, guardian, or adult client)

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Emergency Medical Non-Consent

If the undersigned does not desire to grant any *Horse Sense of the Carolinas, Inc* affiliate/employee/intern/volunteer information or to make health care decisions for the client if the undersigned is unavailable, please initial on the line below and state the procedures to be followed if the client becomes ill or is involved in an accident and the undersigned is unavailable.

_____ I Do Not Consent to any *Horse Sense of the Carolinas, Inc.* affiliate/employee/intern/volunteer obtaining health care information or making emergency health care decisions concerning the client.

Procedures to be followed: _____

Date: _____ Signature: _____

(parent, guardian, or adult client)