Summit County Fair Medical Form

Full Name _____ Birthdate_____

Emergency Contacts		
Name	**Number**	**Relationship**
1.		
2.		
3.		

Please circle all conditions that you have experienced:

Allergies Diabetes Fainting Asthma Other: _____

Are there any physical restrictions that may prevent you from participating in any equine events? Yes/No

If yes, please explain:_____

Are you under a physician's care at this time? Yes / No

If yes, please explain:_____

Are you currently taking any medication? Yes / No

If yes, please explain:_____

Dr.'s Name _____ Phone _____

Address _____City _____ Zip_____

Parents/Guardians,

We hope that this information will never be needed, but we request that you please fill this form out completely. Lacking information can delay treatment at a medical facility for your child. This information will be kept in the Horse Show office and will be used for medical information. I,_____ , (parent's/guardian's name) give the Horse Show Staff/volunteers permission to seek professional medical care for the participant in case of a medical emergency, illness, or injury. I give consent for any show staff/volunteer to act in good faith and without willful misconduct as stated by the GOOD SAMARITAN LAW. I understand that the staff/volunteers are not responsible in the event of accidental injury or illness, nor for compounded injury or illness to the participant's present medical conditions. All illnesses and injuries will be assessed by EMS personnel on the grounds. Medical emergencies will be taken to a more advanced medical facility. The Summit County Fairboard and/or Summit County Jr. Fairboard is unable to pay for visits to the emergency room, doctors' offices, or for prescriptions. In the event that verbal consent cannot be made by phone from the parent/guardian or emergency contact numbers, I give written consent to the attending physician to hospitalize, secure proper treatment and to order injection, anesthesia, or surgery for the participant named above. I understand that I am responsible for payment for the treatment.

Parent's/Guardian's Signature _____ Date _____