

Medical Card

Fill in all the details below and wear this card every time you compete.

Date: _____

NAME (IN FULL):

DATE OF BIRTH:

PERMANENT ADDRESS:

POSTAL CODE:

TEL. NO.:

Allergies: Drug Food Environment

Please Specify:

NAME OF YOUR PHYSICIAN:

ADDRESS:

TEL NO.:

Health Card # & Prov.: _____

EMERGENCY CONTACT:

RELATIONSHIP:

ADDRESS:

POSTAL CODE:

TEL NO:

HORSE TRAILER DETAILS

MAKE:

COLOUR:

REGISTRATION NUMBER:

NOTE: This medical card is the property of the rider. Due to personal info contain hereon, this completed card is not to be reproduce in any form.

If you have difficulty in completing this Medical card, Please contact your physician.

MEDICATIONS: Please specify all current medications

PREVIOUS MEDICAL HISTORY

Previous Injuries/conditions	Yes	No	Date (dd/mm/yy)
Head			
Concussion			
Face			
Neck			
Back			
Chest			
Abdomen			
Limbs			
Previous Surgical Operations			

If yes for any above, Please specify

MEDICAL CONDITIONS

Diabetes			
Epilepsy			
Blackouts			
Asthma			
Heart			
Lung			
Other (including renal)			

If yes for any above, Please Specify

SUPPLEMENTARY INFORMATION

Normal Sight			
Normal Pupils			
Contact Lenses			
Normal Hearing			
Are you on Cortisone?			
Have you ever required Cortisone Treatment			
Blood Group (if known)			
Date of last Tetanus immunization			