

VALID THROUGH: **August 1,** \_\_\_\_\_

PARTICIPANT NAME: \_\_\_\_\_

# PARTICIPANT MEDICAL FORM

**Davis Rodeo Club, UC Davis**

Participant Name: \_\_\_\_\_

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

Address: \_\_\_\_\_

Age: \_\_\_\_\_

Phone: \_\_\_\_\_

Gender: \_\_\_\_\_

Insurance Carrier/#: \_\_\_\_\_

1. Respiratory Problems? Asthma?	Yes No	2. Neurological problems? Epilepsy? Migraines?	Yes No
3. Diabetes? If yes, do you use insulin and how often?	Yes No	4. Cardiac problems? If yes, please list in space(s) provided.	Yes No
5. Knee, hip, ankle, shoulder, arm, or back injuries/operations? If yes, please list body part and date of injury.	Yes No	6. Any allergies? If yes, please specify.	Yes No
7. Allergic to insect bites or bee stings? If yes, do you carry an epinephrine pen?	Yes No	8. Food allergies? Dietary restrictions? Vegan? Vegetarian? If yes, please specify.	Yes No
9. Allergic to any medications? If yes, please list medication and symptoms in space(s) provided.	Yes No	List medication and symptoms here:	
10. Currently taking any medications? If yes, please specify in space(s) provided.			Yes No

Medication	Dosage (Amt./Freq.)	Side Effects/Restrictions

11. Date of last tetanus inoculation: \_\_\_\_\_

12. Please list any medical or physical problems that are not covered in the above listed questions that may affect your participation in this activity. Write N/A if it is not applicable.

## EMERGENCY CONTACT INFORMATION

Name: \_\_\_\_\_

Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Relationship: \_\_\_\_\_

Phone: \_\_\_\_\_

Phone: \_\_\_\_\_

Alt. Phone: \_\_\_\_\_

Alt. Phone: \_\_\_\_\_

Participant Printed Name (if over 18 yrs. of age)

Participant Signature

Date

I, the parent/guardian of the minor child listed above, give permission for any adult employee of the Campus Recreation Department into whose care said minor child has been entrusted to seek emergency medical care for my child at a nearby hospital or medical facility, in the event of illness or injury. I, the parent/guardian, will assume any and all financial responsibility for such emergency medical treatment.

Parent/Guardian Printed Name

Parent/Guardian Signature

Date