COMPLETE ALL SECTIONS

PRIMARY PHYSIC MEDICAL HISTORY

Any serious illnesses? (diabetes, heart disease, seizures, asthma):	ADDRESS:		
Recent surgery?	PHONE:		
Are you pregnant: No Yes No Yes			
Head Injury or Concussion(s): List dates:	HEALTH INSURANCE INFORMATION:		
Neck or Back Injuries: List dates: Fractures or Dislocations:	CARRIER:		
List dates: Chest or Abdominal Injuries:	INSURED/NAME OF		
List dates:	CARDHOLDER:		
Normal Hearing? Normal Immunization Date:			
Current Medications:			

CIAN	(E)	JSPC	MEDICAL	CARD
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NAME:	
DATE OF BIRTH:	MF
ADDRESS:	
PHONE:	
ALLERGIES (all):	
EMERGENCY CONTACT: (N	ALIST RE OTHER THAN SELE
NAME:	
PHONE:	
PHONE:	
NAME:	
PHONE:	
PHONE:	
NAME:	
PHONE:	
DHONE.	

RELEVANT INJURIES AND MEDICAL CONDITIONS

Date of Diagnosis/ Accident	Type of Injury/ Severity of Condition	Treating Doctor Name/Phone







MEDICAL RELEASE CARD

USPC • 4041 Iron Works Pkwy • Lexington, KY 405118483 • (859) 2547669 • memberservices@ponyclub.org

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The purpose of the USPC Medical Card is to allow a USPC member to receive medical treatment in the absence of parent/legal guardian, provide handy emergency contact information and medical history for emergency medical personnel. It is the responsibility of the parent/guardian to complete the Medical Card, update the card when necessary, and ensure that the USPC member wear the card in an armband at all Pony Club activities.

Section 1. ASSUMPTION OF RISK AND WAIVER

I understand that there are inherent risks of serious injury, including head injury, or even death possible with equine activities. I hereby, intending to be legally bound, for myself, my heirs, and assigns, executors and administrators, waive and release forever any and all liability, and all claims for damages against The United States Pony Clubs, Inc. (USPC), Board of Governors, Instructors, Administrators, Volunteers and/or Employees for any and all injuries and/or losses I/my son/my daughter/my ward may sustain associated with my child's voluntary participation in USPC activities.

DATE

ORIGINAL SIGNATURE OF USPC MEMBER APPLICANT
REQUIRED IF APPLICANT IS OF THE AGE OF MAJORITY

Section 2. USPC MEDICAL WAIVER AND TREATMENT RELEASE

ORIGINAL SIGNATURE OF APPLICANT'S PARENT OR LEGAL GUARDIAN
REQUIRED IF APPLICANT IS UNDER THE AGE OF MAJORITY
IN THEIR STATE OF RESIDENCE

DATE



In consideration of my/my child's participation in a United States Pony Club, Inc. (USPC) activity, and the inherent risks of equine activity that may result in injury/harm requiring emergency medical treatment, I authorize the United States Pony Club, Inc., it successors or assigns, officials, officers, directors, employees, agents and/or volunteers to obtain and release to any USPC activity personnel (including, but not limited to, organizers, instructors, test examiners, chaperons), and to any first aid and safety personnel, medical professionals, and treating medical facility, any information regarding my/my child's medical history, symptoms, treatment, exam results and/or diagnosis.

I acknowledge that it is my/parental/legal guardian's responsibility to ensure that I am/my child is a USPC participating member and am/is wearing a completed Medical Card in an armband at all USPC mounted activities and when working around horses. Furthermore, I acknowledge that USPC leadership shall be advised if I/my child have/has had a head injury or other medical condition and have/has been restricted from activity.

I have read this entire release and agree to it.

and/or

DATE

ORIGINAL SIGNATURE OF USPC MEMBER APPLICANT REQUIRED IF APPLICANT IS OF THE AGE OF MAJORITY IN THEIR STATE OF RESIDENCE ORIGINAL SIGNATURE OF APPLICANT'S PARENT OR LEGAL GUARDIAN
REQUIRED IF APPLICANT IS UNDER THE AGE OF MAJORITY
IN THEIR STATE OF RESIDENCE

DATE



