Reins of Hope Riding Program

Emergency Contact Information

Participants Name:_____

Address:_____City:_____State:____Zip:_____

Home Phone:_____Cell Phone:_____Email:_____

In the event of an emergency please contact:

1. Name:_____Phone Number:_____
2. Name:_____Phone Number:_____
3. Name:_____Phone Number:_____

Doctor's name:_____Phone Number:_____
Preferred Hospital:_____
Health Care Insurance Co:_____
Allergies:_____
Epi Pen: yes_____ or No_____
Current Medications:

- _____
- _____
- _____
- _____
- _____

Please describe any medical condition requiring special precautions or treatment:

_____

_____

_____