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:

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