## MEDICAL HISTORY

Complete all sections.

• Any serious illnesses? (diabetes, heart disease, seizures, asthma):

_____

• Recent surgery? _____

• Are you pregnant? ❑ No ❑ Yes

| NO | YES | |
|---|---|---|
| ❑ | ❑ | Head Injury or Concussion(s): _____ list dates: _____ |
| ❑ | ❑ | Neck or Back injuries: _____ list dates: _____ |
| ❑ | ❑ | Fractures or Dislocations: _____ list dates: _____ |
| ❑ | ❑ | Chest or Abdominal injuries: _____ list dates: _____ |
| ❑ | ❑ | Normal Vision |
| ❑ | ❑ | Do you wear contacts? |
| ❑ | ❑ | Normal Hearing |

Last Tetanus Immunization Date: _____

Current Medications: _____

_____

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## PRIMARY PHYSICIAN

NAME: _____

ADDRESS: _____

_____

PHONE: _____

HEALTH INSURANCE INFO:

CARRIER: _____

GROUP #: _____

RIDER'S NATIONALITY: _____

United States Eventing Association
525 Old Waterford Rd. NW
Leesburg, VA 20176
Phone: (703) 779-0440 • Fax: (703) 779-0550
Email: info@useventing.com
Web: www.useventing.com

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## USEA MEDICAL CARD

NAME: _____

DATE OF BIRTH: _____ ❑ M ❑ F

ADDRESS: _____

_____

_____

PHONE: _____

BLOOD TYPE (if known): _____

ALLERGIES TO MEDICINE: _____

_____

EMERGENCY CONTACT:
(MUST BE OTHER THAN SELF) _____

_____

PHONE: _____

## RECORDABLE ACCIDENTS

All competitors must complete this section.

| ACCIDENT DATE | COMPETITION | INJURY | TREATING DOCTOR NAME/PHONE | SUSPENSION PERIOD | CLEARANCE DOCTOR NAME/PHONE | DATE CLEARED |
|---|---|---|---|---|---|---|
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