

St. Andrews Presbyterian College Equestrian Department

Health Information Summary

(To be completed by all students participating in the Equestrian Program)

Please mail this completed form with the Student Health and Wellness Center form.

Student's Full Name _____
Last First MI Name called

Home Address _____ Phone _____
Street Address City State Zip code

Date of Birth ____/____/____ Sex ____ Age ____ Height ____ Weight ____

Name of Parents/Guardian _____

Emergency Contact Numbers: (H) _____ (W) _____ Cell _____

Health Insurance Information Required. Please Submit Both Sides of Insurance Card.

Name of Insurance Company _____

Claims Address _____

Name of Policyholder _____

Policy Number _____ Group Number _____ Phone _____

Is Pre-authorization required for services? **YES NO** (If yes, please include how to receive pre-authorization)

Authorization and Consent

Statement by Equestrian Student or Parent /Guardian, if Equestrian Student is under age 18

This authorization allows our coaches to refer you to a physician for treatment or obtain emergency treatment for you while you are an Equestrian Student at St. Andrews. If you are over age 18, we will proceed without notifying parents prior to treatment. If you are under 18, your parent or legal guardian must also sign this authorization. This authorization is also required to comply with the Health Insurance Portability and Accountability Act (HIPAA) of 1996. HIPAA was created to protect the privacy of personal health information (PHI). HIPAA regulations prohibit the disclosure of PHI unless written authorization is given. Therefore, in order to communicate with your coaches, parents/guardians or health care providers about your injury and/ or condition, Student Health Services must obtain your permission.

- A. I understand that participation in equestrian activities requires an acceptance of risk for injury.
- B. I hereby authorize any medical treatment for myself (my son/ daughter) that may be advised or recommended by Student Health Services. I understand that I am responsible for all incurred medical costs.
- C. I understand that I (my son/ daughter) must refrain from riding while ill or injured.
- D. I hereby give permission to the Student Health Center to disclose my (my son's/ daughter's) personal health information when it pertains to my (his/ her) athletic injury/illness, treatment and/or ability to participate in equestrian activities to my (his/her) coaches, parents/guardians, and/or other health care providers involved in my (his/her) medical care.

Equestrian Student Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

(if student is under age 18)

Medical History

Allergies:

Latex	YES	NO
Aspirin	YES	NO
Other Drug?	YES	NO
What? _____		
Any food?	YES	NO
What? _____		
Bee stings	YES	NO
Insect bites	YES	NO
Hay	YES	NO
Dust	YES	NO

Personal History:

Do you smoke?	YES	NO
Do you drink?	YES	NO
Are you on a special diet?	YES	NO
Are you a vegetarian?	YES	NO
Have you lost weight in the past year?	YES	NO
If yes, how much? _____		
Have you gained weight in the past year?	YES	NO
If yes, how much? _____		
Do you think you have an eating disorder?	YES	NO
Have you had a fall from a horse this year?	YES	NO
If yes, did you require a doctor's care?	YES	NO
Do you learn better visually or orally? _____		

Health History:

Do you now or have you in the past any of the following:

Concussion	YES	NO
Epilepsy	YES	NO
Seizures	YES	NO
Heat-related illness	YES	NO
Blindness	YES	NO
Deafness	YES	NO
Asthma	YES	NO
Heart condition	YES	NO
Arthritis	YES	NO
Skin Cancer	YES	NO
Neck injury	YES	NO
Back injury	YES	NO
Knee injury	YES	NO
Ankle or foot injury	YES	NO
Broken bone	YES	NO
Surgery	YES	NO
Muscle weakness	YES	NO

For any YES answer, please explain

PHYSICIAN'S AUTHORIZATION FOR PARTICIPATION IN THE EQUESTRIAN PROGRAM

Equestrian participation includes horseback riding lessons, trail and cross country riding, unsupervised practice riding, stable work with and around horses, and equestrian competitions.

Equestrian Participation Approved: YES _____ NO _____

Limitations: _____

Physician's Signature: _____ Date: _____