Grand Valley Equine Assisted Learning Center
Medical Information Form

Name of Participant / Volunteer: _____

Parent(s) or Guardian(s): _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Age of Participant/Volunteer: _____ Birth Date: _____ Grade: _____

Family Physician: _____ Phone: _____

Medications Taken: _____

Allergies: _____

Other Pertinent Health Information: _____

Medical Insurance Company: Group No.: _____

Medical Insurance ID No.: _____ Phone: _____

Emergency Contacts:

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____