



Medical History Form

Horse Sense of the Carolinas, Inc.

Client's Full Name: _____ Date of Birth: _____

Street Address: _____

City, State, Zip: _____

Phone(s): H: _____ W: _____ C: _____

Height: _____ Weight: _____ Tetanus Shot within the last 10 Years: Yes [] No []

Medications & Dosage	Taken Since	Prescribed By (Physician)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please indicate if participant has an issue and/or surgeries in any of the following areas by checking "yes" or "no". If "Yes", please comment.

AREA	YES	NO	COMMENTS
Auditory			
Visual			
Speech			
Cardiac			
Circulatory			
Pulmonary			
Neurological			
Muscular			
Orthopedic			
Allergies			
Emotional/Mental Health			
Behavioral			
Bone/Joint			
Learning Disability			
Independent Ambulation			
Crutches			
Braces			
Wheelchair			
Other:			

People with bee allergies should carry their epi pen at all times while on the farm.

Please complete the following if participant is affected by the following conditions:

CONDITION	YES	NO	QUESTIONS
Is participant affected by seizures?			Date of last seizure? _____ Are the controlled? _____ How Frequent? _____
Does participant have any tactile sensitivities?			Examples:
Does participant have any allergies to dust, hay, animals, pollen, or seasonal environments?			Examples:

By signing this form, I, _____ (please print parent/guardian/adult client name) certify all information to be complete and true to the best of my knowledge.

Clients Signature: _____ Date: _____
 Parent/Guardian’s Signature (if client is minor) _____ Date: _____

Warning: Under North Carolina Law, an equine activity sponsor or equine professional is not liable for an injury to or the death of a participant in equine activities resulting exclusively from the inherent risks of equine activities. Chapter 99E of the North Carolina General Statutes.