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: _____

CARD #: _____

SOCIAL SECURITY #: _____

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: _____

ALLERGIES TO MEDICINE: _____

_____

_____

EMERGENCY CONTACT:
(MUST BE OTHER THAN SELF) _____

_____

PHONE: _____

RECORDABLE ACCIDENTS

All competitors must complete.

ACCIDENT DATE	COMPETITION	INJURY	TREATING DOCTOR NAME/PHONE	SUSPENSION PERIOD	CLEARENCE DOCTOR NAME/PHONE	DATE CLEARED