**Riders Interscholastic Federation of North America, Inc. (RIFNA)**
**17875 Birmingham Highway**
**Alpharetta, Georgia 30004**
**Phone: 770-781-3833**
**Fax: 770-888-9418**
**WWW.RIFNA.COM**

# Medical Emergency & Release Form

Please read and complete this form and return a signed copy to your coach as part of your membership application process. It is not mandatory by RIFNA that a copy of this form be maintained by your school advisor; however, please check with your school advisor for his/her policy regarding this form.

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**Section 1: Assumption of Risk and Waiver**

I/We understand that there are inherent risks of serious injury or even death possible with equine activities, and I/We assume the risk for participation in equine activities. On behalf of myself, my heirs and assigns, executors and administrators, I/We hereby waive and release forever any and all liability and all claims for damages against Riders Interscholastic Federation of North America, Inc. (RIFNA), its Board of Governors, Instructors, Administrators, Volunteers and/or Employees for any and all injuries and/or losses I/my son/my daughter/my ward may sustain associated with my child's voluntary participation in RIFNA activities.

______________________________Date_________ ________________________________________ Date ___________

Original Signature of RIFNA Member | Original Signature of Parent(s) or Legal Guardian (required if Member is under 18 years old)

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**Section 2: RIFNA Medical Information and Treatment Release**

In consideration of my/my child's participation in any RIFNA activity and the inherent risks of equine activity that may result in injury/harm requiring emergency medical treatment, I authorize RIFNA (to include its successors or assigns, officials, officers, directors, employees, agents and/or volunteers) to obtain and release to any RIFNA activity personnel (including, but not limited to, organizers, instructors, test examiners, chaperons) AND to any first aid and safety personnel, medical professionals, and treating medical facility, any information regarding my/my child's medical history, symptoms, treatment, exam results and/or diagnosis. I/We have fully disclosed on the **Medical Emergency & Release Form** any pre-existing conditions, allergies, and/or allergic reactions to medication that I/my child has.

Further, by my/our signature below, I/we authorize any medical provider to transport and commence first aid or emergency treatment, for which I/We agree to be liable, until such time that I/we can be contacted to give further Consent to Treatment.

Further, by my/our signature below, I/we hereby authorize any medical professional to accept this form as my/our consent to treat, my/our consent to accept financial responsibility for any and all expenses related thereto, and our agreement to hold RIFNA or its agents harmless.

**I HAVE READ THIS ENTIRE RELEASE AND ACKNOWLEDGE MY AGREEMENT BY:**

______________________________Date_________ ________________________________________ Date ___________

Original Signature of RIFNA Member | Original Signature of Parent(s) or Legal Guardian (required if Member is under 18 years old)

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**Related Information (please print or type)**

Member Name ____________________________ Club ______________________ Region ______________

☐ Parent or
☐ Guardian Names: ______________________________

Address: ______________________________

City/State/Zip: ______________________________

Father Home Phone: ______________ Father Work Phone: ______________ Father Cell Phone: ______________

Mother Home Phone: ______________ Mother Work Phone: ______________ Mother Cell Phone: ______________

**If parent or Guardian is unavailable,**
Contact: ______________________________ Phone: ______________
Contact's Relationship to Member: ______________________________

Family Physician: ______________________________ Phone: ______________

**My child is allergic to**: ______________________________

Other medical conditions: ______________________________

**My child takes the following medication**(s):

______________________________

______________________________

For: ______________________________

Child's date of birth (m/d/y): ______________

**Medical Insurance Information:**
Medical Insurance Company: ______________ Policy Number(s)*: ______________
Please indicate type of insurance: ☐ HMO ☐ PPO ☐ POS ☐ Other

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**Special Instructions**
As parent or guardian of the above-named child, attempt to contact me at the time of the accident or illness without postponing medical treatment. Please list any additional Special Instructions:

______________________________

______________________________

### Other Instructions for Treatment Release

Coach and school advisor must retain this form (with original signatures) on file. Various officials may hold copies, for example: medical personnel on site, instructors, test examiners, and chaperones.

### Report of Existing Medical Condition(s)

Does the above named RIFNA member have any medical condition(s) that may be affected by mounted or unmounted participation in RIFNA activities? ☐ Yes* ☐ No

*If Yes, please describe as specifically as possible:

______________________________________________________________________________

______________________________________________________________________________

### Penalty

The failure to provide the RIFNA leaders with information regarding a member's a medical condition/disability and to comply with the guidelines for notice, medical participation release, and consent requirements shall require that the member be disqualified from participation in RIFNA activities, and shall be a material misrepresentation that the RIFNA member has no medical condition/disability which might affect his/her participation.

### Returning following injury

In the event that member rider is injured, a physician's release will be necessary before member can resume equine activities through RIFNA.

### Initial Physician's Release

Your school may require a physical before allowing you to participate in the Equestrian Club. If they do, please ask the attending physician to complete the following form. If no physical is required by your school, please ask your family physician to complete the Physician's Release statement on this form.

**Physician's Release**

Member's Name: ______________________________________

DOB: __________________

is making application to participate in equine activities through Riders Federation of North America, Inc.

Physician's Name: _________________________________ Office Phone: ______________________

Physician Address: ________________________________________________________________________

City/State/Zip: _____________________________________________________________________

Licensure No.: _______________________________________ State of: ___________________

The above named member has been seen by my on (date): _________________________________

The date of this patient's most recent Tetanus shot is: ________________________________________

Medical Conditions: _________________________________________________________________

_____________________________________________________________________________________

_____________________________________________________________________________________

Limitations: (use additional page if necessary to explain): ____________________________________

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*I hereby release the above named RIFNA member to participate in mounted and unmounted equine activities. I am familiar with all of the requirements of RIFNA mounted and unmounted events. If I believe the member may participate in some of the events, but not in others, I have listed them above:*

_________________________________________ ______________________

**Signature of Physician** **Date**