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| Participant Medical Consent Form - To be completed by Rider/Parent/Legal Guardian |
| Participant Name |  | Date of Birth |  |
| Email |  |
| Legal Guardian (if Participant is < 18 years) |  | Phone |  |
| Address |  |
| I give my permission for the sharing of relevant medical information for the purpose of establishing a riding programme. Information will be regarded as confidential, with storage and use only in accordance with the privacy Act 2020. |
| Signature |  | Date |  |
| **Known medical history and information – To be completed by the Physician.** |
| Diagnosis / Condition | Other relevant information Relevant precautions |
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| **Physician Consent -** In my opinion this person can participate in a Taupo riding for Development programme and associated activities with appropriate supervision. |
| Physician name |  |
| Signature |  | Date |  |
| Address |  |
| Return information received |
| Please return completed form to | tauporfd@gmail.com PO Box 541 Taupo 3330 |
| Received by |  | Date |  |