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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](mailto:tauporfd@gmail.com) PO Box 541 Taupo 3330 | | | | |
| Received by | |  | Date | | |  |