



## MEDICAL FORM

102 Young Rider Lane, Jarvisburg NC 27947

252.491.5090

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### Participant

Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_ Zip: \_\_\_\_\_

### Phone:

Home: \_\_\_\_ . \_\_\_\_ . \_\_\_\_\_

Cell: \_\_\_\_ . \_\_\_\_ . \_\_\_\_\_

Work: \_\_\_\_ . \_\_\_\_ . \_\_\_\_\_

### Emergency Contact Information:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

### Phone:

Home: \_\_\_\_ . \_\_\_\_ . \_\_\_\_\_

**Phone:**

**Cell:** \_\_\_\_ . \_\_\_\_ . \_\_\_\_\_

**Work:** \_\_\_\_ . \_\_\_\_ . \_\_\_\_\_

**Known Allergies/Medical Concerns:** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**Insurance Information (a copy of a health insurance card is required for verification)**

**Family Physician:** \_\_\_\_\_

**Phone:** \_\_\_\_ . \_\_\_\_ . \_\_\_\_\_

**Address:** \_\_\_\_\_

\_\_\_\_\_

**City:** \_\_\_\_\_ **State:** \_\_\_\_ **Zip:** \_\_\_\_\_

**Insured Name:** \_\_\_\_\_

**Group Name/Identification#:** \_\_\_\_\_

**Address:** \_\_\_\_\_

\_\_\_\_\_

**City:** \_\_\_\_\_ **State:** \_\_\_\_ **Zip:** \_\_\_\_\_

**List any medication or other medical concerns:** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**Authorization:** I hereby authorize any medical treatment deemed necessary in the event of any injury while on Wrangler Farms, LLC property. I have insurance or, if I do not have insurance, I agree to pay all costs of rescue and/or medical services as may be incurred on my/our behalf. I also give permission for Linda Barber, Wendy Robinson or their designee(s) to administer prescription medications as prescribed by a physician.

**I have reviewed and fully agree with the terms of this Medical Form.**

\_\_\_\_\_ **Date** \_\_\_\_\_

**Participant Name**

\_\_\_\_\_ **Date** \_\_\_\_\_

**Parent/Guardian ( Signature )**

\_\_\_\_\_ **Date** \_\_\_\_\_

**for Wrangler Farms, LLC**