KICK ON COACHING

Name _____ **Date of Birth** _____

Next of Kin _____

Address of Next of Kin _____

_____

Telephone Number - Day _____ **Night** _____

Email _____

General Practitioner _____

Name & Address of Practice _____

_____

Do you suffer from:

* Asthma	YES / NO	* Epilepsy / Fainting	YES / NO
* Migraine	YES / NO	* Diabetes	YES / NO
* Dyslexia	YES / NO	* Hay Fever	YES / NO
* Heart / Lung Disorder	YES / NO	* Bone / Joint Impairment	YES / NO
* Vision / Hearing Defects	YES / NO	* Allergy to Drugs / Food	YES / NO
* Gynaecological Disorders	YES / NO	* Ear, Nose & Throat	YES / NO
* Gastro-intestinal Disorders	YES / NO	* Any skin complaint	YES / NO

Are contact lenses worn? _____ Religion, if applicable to Medical Treatment _____

Any other problem which we should be aware of? _____

Do you regularly take any form of Medication, if so what? _____

Are there any current injuries / recent operations / medical treatments? YES / NO If so, please explain overleaf.

Any previous operations, e.g. appendix YES / NO If so, please explain overleaf.

Date of last Tetanus Injection _____ (Any adverse reaction?)

Blood Group (if known) _____

I have read, understood and agreed to Kick on Coaching Term's & Conditions.

I understand that riding at any standard has inherent risk of injury. I accept that risk and agree that Kick on Coaching will not be liable for injury or damage to property unless it is caused by their negligence.

Signed _____ Date _____

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