





# MESQUITE TRAIL RIDE- 2019

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## Medical History Form

Name:

Primary Physician Name:

Physician's Phone:

List Any Medical Conditions:

List Any Medications:

List any Allergies (Bees, food, medication)

**\*\*\*\* I authorize the use of any Field Emergency medical Procedure(s) in the event that I should become ill or injured. \*\*\*\***

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**\*\*\*The return of this form filled out signifies signature has been added electronically. \*\*\*\***