

McHay.com

Bull Riding Series

Name: _____ Nickname: _____

Age: _____ DOB: _____ Address: _____

E-mail address: _____ Home Phone: _____

Parent's Name: _____ Cell Phone: _____

Parent's Name: _____ Cell Phone: _____

Does participant have any bull riding experience? Y___ N___ How many out's? _____

If no, does participant have experience with any other livestock (i.e. Calves, sheep, horses)?

Does participant have all of own equipment? Y___ N___ if yes, are you willing to loan equipment to other rider's? Y___ N___ if no, what equipment do you lack? _____

Siblings name & ages: _____

In Case of Emergency: Name: _____ Relationship: _____

Home Phone: _____ Alternate number: _____

AUTHORIZATION FOR EMERGENCY MEDICAL ATTENTION

In the event that I cannot be reached to make arrangements for emergency medical attention, I authorize the facility director or person in charge to take or have my child transported by ambulance to:

Name of hospital or clinic: _____ Phone: _____

Doctor's Name: _____ Phone: _____

I give consent for necessary emergency treatment when my child is in care of this hospital/ clinic and/or doctor.

Parent or Guardian Signature

Date

RELEASE WAIVER AND AUTORIZATION FOR MEDICAL CARE OF A MINOR

(PLEASE PRINT NAME)

The undersigned parent having legal custody or the legal guardian of:

(PLEASE PRINT CHILD'S NAME)

DO HEREBY AUHTORIZE the **McHay.com Bull Riding Series** staff or personal to any x-ray, examination, anesthetic, medical, surgical, or dental diagnosis treatment and hospital care to be rendered to the above minor under general and/or special supervision and upon the advise of a physician, surgeon, or dentist licensed under the laws of the State of Oklahoma (or the State where the injured athlete is located)

In giving this consent, I recognize and understand that in situations where the above named minor requires immediate medical care it may not be possible to contact me and in such situations I will not be able to evaluate and choose among the available treatments or procedures, if any or to evaluate the risks attendant upon each, and the risks attendant to forgoing all treatment; in such situations, I authorize a physician, surgeon, or dentist to exercise his professional judgment to choose the necessary treatment from any available alternatives and to render such care and perform such treatment as he/she in their professional judgment determines to be necessary for the health or safety of the above mentioned minor.

I, the undersigned, do also hereby release the **McHay.com Bull Riding Series**, and/or any and all of said association officers and/or their representatives of the responsibility for any injury of any kind or nature incurred before, during or after association sponsored or non-association sponsored events.

(DATE)

(Signature of Parent or Legal Guardian)

(Mailing/Home Address)

(City)

(State)

(Zip Code)

Witness Signature: _____ Date: _____

TREATMENT INFORMATION:

Minor Name: _____

Minor DOB: _____

Doctor Name: _____ Phone: _____

Does your child have or has he/she ever had any of the following problems or

Heart? Y___ N___

Seizures? Y___ N___ Date of last seizure? _____ length? _____

Stroke? Y___ N___

Broken bones? Y___ N___

If you answered yes to any of the above questions please explain: _____

Please list any other medical history (i.e. past surgeries, recent illness or injury): _____

Allergies: _____

Current Medications: _____

Date of last Tetanus: _____

Insurance Name: _____ Policy Number: _____