

Adult Information and Medical Release Form

Name of adult student: _____ Date of birth: _____

Address: _____

Home/Cell#: _____

Work#: _____

REQUIRED - Best Email for Communication:

Relative/friend to contact in case of emergency:

Name: _____

Home#: _____

Relationship: _____

Work#: _____

Cell#: _____

Additional Information Required

Allergies: _____

Chronic
Illness: _____

Regular
Medication: _____

Blood Type: _____ Date of last Tetanus _____

Immunization: _____

Physician: _____

Phone: _____

Insurance Co.: _____

Policy#: _____

Insurance
Agent: _____

Phone: _____

Release for Medical Treatment of an Adult:

The undersigned adult student does hereby consent to any x-ray examination, anesthetic, medical or surgical diagnosis, or treatment and hospital service that may be rendered to said adult student under the general or specific instructions of any physician or hospital. It is understood that this consent is given to encourage Summer Hill Farm LLC staff, hospital staff, and such physician to exercise their best judgment as to the requirement for such diagnosis to treatment. The undersigned shall pay all fees for doctors, hospitals, ambulances and other medical charges reasonable and necessarily incurred.

Date: _____ X _____

Signature of Adult Student

Staff Only: Program: ____ Training ____ Riding School Rate: _____

Lesson ____ times per week & days _____

Minor Information and Medical Release Form

Name of Minor: _____ date of birth: _____

Address: _____ Home/Cell#: _____

City/State/Zip: _____

REQUIRED - Best Email for Communication:

Mother: _____ Home #: _____

Address: _____ Work #: _____

City/State/Zip: _____ Cell #: _____

Father: _____ Home #: _____

Address: _____ Work #: _____

City/State/Zip: _____ Cell #: _____

Other relative/guardian to contact in case of emergency:

_____ Home #: _____

Relationship: _____ Work #: _____ Cell #: _____

Allergies: _____ Last Tetanus: _____

Chronic Illness: _____ Disability: _____

Regular Medication: _____ Blood Type: _____

Minor's Physician: _____ Phone#: _____

Insurance Co: _____ Policy#: _____

Release for Medical Treatment of a Minor:

I, _____, parent of _____, a minor, authorize Tom Davenport or any authorized agent of SUMMER HILL FARM LLC consent to emergency medical treatment on behalf of the above named minor.

X _____ Dated this ____ day of _____,
20____

Staff Only: Program: ____ Camp ____ Training ____ Riding School
Rate: _____

Camp Date _____ Lesson ____ times per week & days

I have read and understand the Summer Hill Farm Policies & Procedures and Barn Etiquette and Rules.

Date: _____

Signature of Student or Parent

I have read the above and understand the Payment and Cancellation Policies.

Date: _____

Signature of Student or Parent if minor