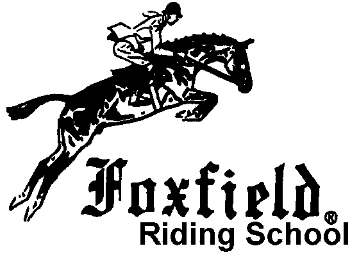

P.O. Box 3576, Westlake Village, CA 91358
(805) 495-5515 FAX (805) 497-1799

MEDICAL RELEASE FORM
(Must be completed for all students under 18 years of age)

Student's Name ______________________________ Home Phone ____________________

Street Address ______________________________ Birth Date ____________________

Student's Age ______ Student's Birth Date ____________________

City ______________________________ State ________ Zip Code __________

Name of Parent or Legal Guardian ______________________________

Street Address (if different from above ______________________________

City ______________________________ State ________ Zip Code __________

Home Phone ______________ Work Phone ______________ Cell Phone ______________

Do you have Health & Accident Insurance? ____________ Pager No. ____________

Please list any health problems or allergies ______________________________

____

Date of last Tetanus shot ____________________

Family Doctor ______________________________ Doctor's Phone ____________________

****

THE UNDERSIGNED PARENT OR LEGAL GUARDIAN OF SAID STUDENT, A MINOR, HEREBY CONSENTS TO ANY X-RAY EXAMINATION, ANESTHETIC, MEDICAL OR SURGICAL DIAGNOSIS OR TREATMENT AND HOSPITAL SERVICE THAT MAY BE RENDERED TO SAID MINOR UNDER THE GENERAL OR SPECIFIC INSTRUCTIONS OF ANY PHYSICIAN OR HOSPITAL. IT IS UNDERSTOOD THAT THIS CONSENT IS GIVEN IN ADVANCE OF ANY SPECIFIC DIAGNOSIS OR TREATMENT WHICH MAY BE REQUIRED, BUT IS GIVEN TO ENCOURAGE THE FOXFIELD RIDING SCHOOL STAFF, HOSPITAL STAFF AND SUCH PHYSICIAN TO EXERCISE THEIR BEST JUDGMENT AS TO THE REQUIREMENTS OF SUCH DIAGNOSIS OR TREATMENT. THE UNDERSIGNED SHALL PAY ALL FEES FOR DOCTORS, HOSPITALS, AMBULANCES AND OTHER MEDICAL CHARGES REASONABLE AND NECESSARILY INCURRED.

Date ________________

______________________________ ______________________________

Print Parent's or Legal Guardian's Name   Parent's or Legal Guardian's Signature