

P.O. Box 3576, Westlake Village, CA 91359
(805)495-5515 FAX (805)497-1799
www.foxfield.com

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

Student's Name _____ Home Phone_____

Street Address_____

City_____ State_____ Zip Code_____

Birth Date_____ Student's Age _____

Name of Parent or Legal Guardian_____

Street Address_____

City_____ State_____ Zip Code_____

Home_____ Cell_____ Work_____

Do you have Health and Accident Insurance? _____

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 or Legal Guardian's Signature