



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