

MEDICAL RELEASE

Rider

First Name: _____ Last Name: _____

Email: _____ Birthday: _____

I hereby authorize Hilary Johnson or any other employee of Rose Hill Stables, to seek medical attention for myself or for myself or for my child in the event of an emergency.

First Name: _____ Last Name: _____

Address: _____

Email: _____ Phone #: _____

Gender (optional): _____ Birthday: _____

Insurance Company: _____ Policy Number: _____

Primary Doctor: _____ Doctor Phone #: _____

Allergies: _____

Other Medical Information: _____

Drivers License: _____ Social Security: _____

Parent or Spouse's Name: _____ Parent/Spouse Phone #: _____

Emergency Contact: _____ Emergency Phone #: _____

I agree to use electronic records and signatures

Please sign here: _____

Date: _____

I agree to use electronic records and signatures

Parent signature, if a minor: _____

Date: _____