EMERGENCY MEDICAL INFORMATION

PRIMARY CARE PHYSICIAN:_____________________________ PHONE: _____________________

INSURANCE CARRIER:_______________________________ POLICY#:_______________________

NAME OF POLICY HOLDER: __________________________ RELATION TO PATIENT:_________

PREFERRED HOSPITAL: ____
(In case of emergency)

PERSONS TO CONTACT IN AN EMERGENCY

____ Home: _________________________
Cell: _________________________
Work: _________________________

____ Home: _________________________
Cell: _________________________
Work: _________________________

____ Home: _________________________
Cell: _________________________
Work: _________________________

CONSENT FORM

I ____, do hereby give my consent to **SPRING DOWN EQUESTRIAN CENTER** and any of it's employees or representatives to have myself treated by any physician or surgeon in case of sudden illness or injury while at **SPRING DOWN EQUESTRIAN CENTER**.

X____

MINOR CONSENT FORM

I, ____, do hereby give my consent to **SPRING DOWN EQUESTRIAN CENTER** and any of it's employees or representatives to have my child treated by any physician or surgeon in case of sudden illness or injury while at **SPRING DOWN EQUESTRIAN CENTER**.

X ____