Authorization for Medical Treatment

Dear Parent or Guardian:
While you are away, your child may need medical attention. To avoid delay in obtaining your consent, to make clear your choice of physician and provide other information about your child's healthcare needs, please fill out this form and sign it. This form should be left with the person or institution who will be in charge of your child in your absence. It serves as authorization from you so that your child may receive medical treatment.

Name of person or institution caring for your child during parent or guardian absence Spring Valley Equestrian Center, Inc.

I (We) ____________________
(Parents, Guardians)

of ____________________
(City)

____
(County) (State) (Zip Code)

do hereby state that I am the parent(s)/guardian(s) having legal custody of

____
(Child's Name)

a minor, age ________ (Age of child), born on ____________ (Birthdate) who resides with me (us) at ____________________ (Address)

In the city of ____________________

county of ____________, state of ____________

consent to any X-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital care to be rendered to the minor, at a recognized medical facility, under the general or special supervision of a licensed physician or surgeon.

Dated this ______ day of ____________, 20 ________

____
(Parent's/Guardian's Signature)

MEDICAL INFORMATION

Existing medical problems of child, if any:

Child's allergies, if any:

Child's doctor:

Parent's doctor:

Choice of specialists:

Medicines child is taking:

Insurance company:

Policy Holder: ____________

Group no.: ____________

Identification no.: ____________

Date of last tetanus shot: ____________

Phone no. where you can be reached: ____________

This authorization will expire on ____________

Witness:

Date: ____________

-Please Turn Over-