HIGH STANDARD STABLE

1253 Bragdon Rd. Wells, Maine 04090 | CAMP@HIGHSTANDARDSTABLE.COM | (603) 833-0560

Medical Care and Treatment Release Form

Name:____ Date:_____________Age:_____ Date of Birth:________ Sex:_________

Parent/Guardian:____________________________________Home Address:____

Home Phone:____ Cell Phone:____

Name of Family Doctor:____ Phone:____

Name of Family Dentist:____ Phone:____

If you or you doctor cannot be notified please name another emergency contact:____

____ Phone:____

Health Insurance Company:_______________________________________ Policy Number:____

Name of holder:____ Phone:____

Instructions for Medications
1. All prescription drugs must be carried in the container in which they were issued with medical orders and physician's name intact.
2. All prescriptions drugs brought to any High Standard Stable event must be discussed with the High Standard Stable adult responsible for medical emergencies during the High Standard Stable event. List any medications *(prescription and non-prescription such as pain relievers, aspirin, Tylenol, etc.)* that you take:
____

Please include dosages and any special instructions:____

List approximate date of any recent or current serious illness, operation, or injury:____

____

Date of last Tetanus Booster:_________List any allergies including food, medication, environmental and insects:_________________________________

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Circle below if participant is subject to:

Arthritis Diabetes Kidney Disease Bladder Disease Headaches Convulsion
Fainting Bronchitis Respiratory Problems Asthma Stomach Problems
Intestinal Problems Heart Trouble Ear Infections Homesickness food Allergies Seizures

Other:____

My child is physically able to participate in this program including being around horses and participating in mounted activities. I understand that High Standard Stable members will be supervising and if a serious illness or injury develops medical and/or hospital care will be given. I further understand that in case of medical emergency we will be notified. In the event that I cannot be reached, I hereby give permission to the attending physician to hospitalize, secure Medical Care and Treatment Form and do certify that the information set forth on this form is true and correct to the best of my knowledge. I will assume all financial obligations incurred if not covered by insurance.

Signature of Parent or Guardian:____ Date:____________________________