Full of Grace Farm
Emergency Contact and Medical Form

Participant's name_____ Date of Birth_____

Allergies: _____

Hospital of Choice _____

Dr. _____ Phone#_____

Insurance Co. _____Holders Name_____

***EMERGENCY CONTACTS*:**

***PLEASE NOTE: Emergency Contact- Must be available during program days & hours.**

Primary name: _____Phone#_____

Alternate: _____Phone#_____

Additional Comments &/or Health Concerns:

_____

_____

_____

I, _____hereby authorize Full of Grace Farm / J&L Equine owners, employees, and agents to secure any medical services as they deem necessary for myself. I hereby agree and am legally bound to pay for any and all costs related to such medical services, including costs not covered by my medical or other insurances.

_____

Print Name

_____ _____

Signature *Date*