

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 hours, 9am-3pm***

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:

_____ (*minor's name*). 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 (Legal Parent / Guardian of minor-- listed above)

Signature (Legal Parent / Guardian of minor-- listed above)

Date