



**MEDICAL RELEASE FORM CONSENTING ADULT**

I, \_\_\_\_\_, request that should I become injured while at Sandy Bay Stables and or working with Doug Cross and/or Amy Goumillout, the farm workers, representatives, owners, instructors and agents have my explicit permission to call 9-1-1 and have me brought to the hospital by ambulance. I request and fully authorize physicians, dentists, and staff, duly licensed as Doctors of Medicine or Doctors of Dentistry or other such licensed technicians or nurses, to perform any diagnostic procedures, treatment procedures, operative procedures and x-ray treatment on me in the event I may be unconscious or not of clear sound mind. I understand that I have not been given a guarantee as to the results of examination or treatment. Doug Cross & Amy Goumillout assures that in the event of an injury they will make their best effort to contact my emergency person listed below.

**PRINT YOUR FULL NAME:** \_\_\_\_\_ **Date of birth:** \_\_\_\_\_

**Address:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

Street Address City/Town State Zip

**Date of last Tetanus Booster:** \_\_\_\_\_ **Known allergies including any allergies to medicine?**

Current medical conditions being treated for: \_\_\_\_\_

Past medical conditions & Past surgeries? \_\_\_\_\_

Medications currently taking and the dosage amounts: \_\_\_\_\_

**Family Physician:** \_\_\_\_\_

**Address:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Other Specialists involved in current treatment:**

**Address:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Name of Parent(s):** \_\_\_\_\_

**Address(es):** \_\_\_\_\_

Street address City/Town State Zip

**Phone(s)** \_\_\_\_\_

**Name of PERSON TO CONTACT IN EMERGENCY: CLOSEST RELATIVE**

**Address:** \_\_\_\_\_

Street address Town/City State Zip

**Phone** H \_\_\_\_\_ W \_\_\_\_\_ W \_\_\_\_\_

**Cell** \_\_\_\_\_, \_\_\_\_\_

**INSURANCE CARRIER:** \_\_\_\_\_ **Policy Number** \_\_\_\_\_

**SIGNATURE** \_\_\_\_\_ **Date:** \_\_\_\_\_

**WITNESS** \_\_\_\_\_ **Date:** \_\_\_\_\_