



PEBBLE BEACH  
EQUESTRIAN CENTER

## MEDICAL RELEASE

### FOR STUDENTS UNDER 18 YEARS OF AGE

Name of Student \_\_\_\_\_ Home Phone \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Student's Age \_\_\_\_\_ Birth Date \_\_\_\_\_

Name of Parent or Legal Guardian \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Home Phone \_\_\_\_\_ Business Phone \_\_\_\_\_

Do you have Health and Accident Insurance ? \_\_\_\_\_

State any Health Problems or Allergies \_\_\_\_\_

Date of Last Tetanus Shot(Check with your Doctor concerning this) \_\_\_\_\_

Family Doctor \_\_\_\_\_ Doctor's Phone \_\_\_\_\_

THE UNDERSIGNED, PARENTS OF STUDENT, A MINOR, DO HEREBY CONSENT TO ANY X-RAY EXAMINATION, ANESTHETIC, MEDICAL OR SURGICAL DIAGNOSIS OR TREATMENT HOSPITAL SERVICE THAT MAY BE RENDERED TO SAID MINOR UNDER THE GENERAL OR SPECIFIC INSTRUCTIONS OF ANY PHYSICIAN OR HOSPITAL. IT IS UNDERSTOOD THIS CONSENT IS GIVEN IN ADVANCE OF ANY SPECIFIC DIAGNOSIS OR TREATMENT WHICH MAY BE REQUIRED, BUT IS GIVEN TO ENCOURAGE THE PEBBLE BEACH EQUESTRIAN CENTER STAFF, HOSPITAL STAFF, AND SUCH PHYSICIAN TO EXERCISE THEIR BEST JUDGMENT AS TO THE REQUIREMENTS OF SUCH DIAGNOSIS OR TREATMENT. THE UNDERSIGNED SHALL PAY ALL FEES FOR DOCTORS, HOSPITALS, AMBULANCES AND THEIR MEDICAL CHARGES REASONABLE AND NECESSARILY INCURRED.

Date \_\_\_\_\_

\_\_\_\_\_  
PRINT PARENT'S NAME

\_\_\_\_\_  
PARENT'S SIGNATURE