**MEDICAL INSURANCE and TREATMENT CONSENT FORM**

The following form is designed for those situations where there may be a medical incident that occurs while participating in equestrian events or while on facility property. It is required that ALL persons on the property of Cavallo Creek or adjacent properties owned by Denise Frisco or Matthew Keefe be required to provide treatment and insurance information. In the event that a person is incapacitated, this form gives authority to a designated adult to arrange for medical care in the event of an emergency. This is extremely important, in that, medical care can not be provided to a minor without approval by the parents or legal guardians, unless there is written consent authorizing an agent to give approval.

_____ _____/_____/_____
*Full Name* *Date of Birth*

_____
*Address (City, State, Zip Code)*

The undersigned do hereby authorize Denise Frisco / Holly Croft / Matthew Keefe or such substitute as he/she may designate as agent for the Undersigned to consent to any X-Ray, anesthetic, medical, dental, or surgical diagnosis or treatment and hospital care for the above named minor which is deemed advisable by and to be rendered under the general or special supervision of any physician and/or surgeon, licensed under the Provision of Medicine Practice Act or of any dentist licensed under the Dental Practice Act, whether such diagnosis or treatment is rendered at the office of said physician or dentist, at a hospital, or elsewhere. Please include a copy of your insurance card and a government issued photo ID.

_____ _____/_____/_____
*Signature* *Date*

_____
*Name*

_____
*Address*

*(_____) _____-_____Home (_____) _____-_____Work (_____) _____-_____Cell*
*Home Work and Cell Phones*

_____
*Witness*

_____
*Insurance Company*

_____ *(_____) _____-_____ (_____) _____-_____*
*Insurance Company Address* *Phone* *Phone/Fax*

_____ _____
*Insurance ID#* *Group #*

_____
*Primary Insurer and Account Number*

_____ *(_____) _____-_____ (_____) _____-_____*
*Family Physician* *Phone* *Phone/Fax*

_____
*Family Physician's Full Address*

_____
*Preferred Emergency Provider or Hospital*