

**Leone Equestrians, Inc.  
Medical Release Form**

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Must be completed for all students under 18 years of age

Student's Name \_\_\_\_\_ Home Phone \_\_\_\_\_

Street Address \_\_\_\_\_ Birth Date \_\_\_\_\_ Age \_\_\_\_\_

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

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

Street Address (if different from above) \_\_\_\_\_

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

Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

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

Do you have any health problems or allergies \_\_\_\_\_

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

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

Date: \_\_\_\_\_

\_\_\_\_\_  
Print Parent's or Legal Guardian's Name

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Parent or Legal Guardian's Signature