



**FIELD OF DREAMS EQUINE EDUCATION CENTER**

1416 Reynoldsburg-New Albany Road  
Blacklick, Ohio 43004

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www.FieldOfDreamsEquine.com

**EMERGENCY MEDICAL RELEASE FORM**

\_\_\_\_\_  
Name of Participant

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
City

\_\_\_\_\_  
State

\_\_\_\_\_  
Zip Code

\_\_\_\_\_  
Home Telephone Number

\_\_\_\_\_  
Work Telephone Number

\_\_\_\_\_  
Other Telephone Number

\_\_\_\_\_  
Type of Telephone Number

**PERSON TO CONTACT IN CASE OF AN EMERGENCY SITUATION:**

\_\_\_\_\_  
Name of Emergency Contact

\_\_\_\_\_  
Home Telephone Number

\_\_\_\_\_  
Work Telephone Number

\_\_\_\_\_  
Medical Insurance Company

\_\_\_\_\_  
Policy Number

\_\_\_\_\_  
Preferred Medical Facility

\_\_\_\_\_  
Pertinent Medical History:

Allergies (include food allergies): \_\_\_\_\_

Contact Lenses: (circle) Y N Name Medical Doctor: \_\_\_\_\_

Doctor Telephone Number: \_\_\_\_\_ Date of Last Tetanus Shot: \_\_\_\_\_

**RELEASE FOR AN ADULT PARTICIPANT**

If emergency medical care is required for me and if I am not able to convey permission in a timely manner, then the undersigned authorizes appropriate emergency medical care as deemed necessary by emergency medical personnel, a physician or the medical facility providing treatment.

\_\_\_\_\_  
Signature of Adult Participant

\_\_\_\_\_  
Date

**RELEASE FOR A MINOR**

If emergency medical care is required for (child's name) \_\_\_\_\_ and if any permission is not available in a timely manner, then the undersigned authorizes appropriate emergency medical care as deemed necessary by emergency medical personnel, a physician or the medical facility providing treatment. I have read this entire release and agree to it:

\_\_\_\_\_  
Signature of Parent or Guardian (Rider if older than 18)

\_\_\_\_\_  
Date