2014 Summer Riding Experience Medical Consent Form

I/We, the parent(s) or legal guardian(s) of _____, hereby authorize the Faculty and Staff of Summer Riding Experience (The Ethel Walker School) to administer, or cause to be administered to my/our daughter, any health care, treatment or medication (including psychiatric, dental and medical treatment) deemed advisable by a state-licensed medical care provider.

In the event of a health emergency, I/we further consent to the immediate transfer of my/our daughter to any hospital or appropriate health care facility, and authorize a representative of the Summer Riding Experience (The Ethel Walker School) to consent on my/our behalf to any emergency medical, dental, or psychiatric treatment for my/our daughter.

All reasonable attempts to contact me/us in advance of such an emergency, or other non-routine treatment, will be made. If such attempts to contact me/us are unsuccessful, or cause a delay in emergency treatment, I/we understand that the School representative will proceed to secure the best care for my/our daughter as advised by the medical care professional.

This consent may be used for off-campus health emergencies. In such cases, the senior School representative present will provide authorization and consent. This medical consent will remain in effect the entire time your daughter attends Summer Riding Experience.

I/we further authorize the School to release information to facilitate the medical, dental, or psychiatric care of our daughter, and to enable the provider of care to complete a claim for health insurance. I/we agree that I/we are exclusively responsible for the payment of all medical, dental, and psychiatric services rendered to my/our daughter other than routine services provided directly by the School's Health Services Office.

Furthermore, I/we authorize the Director of Health Services and/or the Director of Counseling to release information about my/our daughter to appropriate School representatives only in the event that this information is necessary to provide the best care for my/our daughter.

Any copy of this consent shall have the same force as the original.

_____	_____	_____
Print name of legal guardian one/father	Signature	Date
_____	_____	_____
Print name of legal guardian two/mother	Signature	Date

CONTACT PERSON

_____
Full name

_____	_____	_____	_____	_____
Street address	City	State	Zip code	Country

_____	_____	_____
Day phone number	Evening phone number	Cell phone number
_____	_____	_____
Primary insurance carrier	Name of insured	Policy number

Severe Allergy Information

Name: Date of Birth:

Allergy:

Parent/Guardian to contact:

Relationship to student:

Home Phone:

Mother's Work Phone: Cell Phone:

Father's Work Phone: Cell Phone:

3rd Party contact: Phone:

Family Physician: Phone:

Allergy Doctor: Phone:

Asthmatic and at increased risk for more severe reaction? Yes_____ No_____

Is there an individualized student protocol? Yes_____ No_____

If yes, please attach.

EpiPen location/s: