MEDICAL AUTHORIZATION FORM

We, the undersigned, and parents of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ hereby authorize Walnut Spring Stables to administer or authorize any and all medical treatment for \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ they in their discretion see fit. This includes, but is not limited to, treatment to relieve pain.

A photocopy of this authorization shall be deemed effective as if it were an

Original. This authorization shall remain in effect until July 17th, 2015

MEDICAL INSURANCE COMPANY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MEDICAL INSURANCE ID or GROUP #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MEDICAL INSURANCE CO. PHONE #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PEDIATRICIAN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PEDIATRICIAN PHONE #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please provide a copy of the insurance card with this form.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent Signature DATE

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent Printed Name DATE