

**PROVIDENCE HILL FARM, LLC**  
**P. O. Box 13688**  
**Jackson, MS 39236**  
**601-925-0557**  
**EMERGENCY MEDICAL RELEASE FORM**

Name: \_\_\_\_\_  
Soc. Sec. #: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_  
State: \_\_\_\_\_ Zip: \_\_\_\_\_

**PERSON TO CONTACT IN CASE OF EMERGENCY**

Name: \_\_\_\_\_  
Telephone Nos.: \_\_\_\_\_

**HEALTH INSURANCE**

Medical Insurance Company:

\_\_\_\_\_  
Policy #: \_\_\_\_\_  
Member #: \_\_\_\_\_

**MEDICAL INFORMATION**

Prior Medical History:

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

Allergies:

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

Contact Lenses: \_\_\_\_\_

Medical Doctor: \_\_\_\_\_

Telephone: \_\_\_\_\_

Date of Last Tetanus Shot: \_\_\_\_\_

Other:

\_\_\_\_\_

**RELEASE FOR AN ADULT RIDER**

If emergency medical care is required for myself and if I, or an accompanying spouse or relative, 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. I agree to bear any cost connected therewith and shall pay promptly upon billing by the health care provider. Providence Hill Farm, LLC shall incur no financial liability for medical treatment obtained pursuant to this authorization.

I have read this entire release and agree to it:  
Signature:

\_\_\_\_\_

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

**RELEASE FOR A MINOR RIDER**

If emergency medical care is required for:  
Child's Name:

\_\_\_\_\_  
and if 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. Providence Hill Farm, LLC shall incur no financial liability for medical treatment obtained pursuant to this authorization.

I have read this entire release and agree to it:  
Signature:

\_\_\_\_\_  
*(parent or guardian)*

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

IF AVAILABLE, PLEASE ATTACH A PHOTOCOPY (FRONT AND BACK) OF APPLICABLE MEDICAL INSURANCE CARD.