Wisconsin Interscholastic Horsemanship Association
Permit for Treatment of a Child

Child's Name:_____ Date of Birth:_____

Address:_____ WI _____
Street City State Zip

Child's Physician_____

List Allergies:_____

List Medications:_____

Past Medical History:_____

Insurance Provider: _____

By signing this document, I/we, _____ the parent(s)/legal guardian(s) of _____ authorize my child's coach or the designee listed below to seek first aid and medical attention for my child. I also authorize the Wisconsin Interscholastic Horsemanship Association, and/or designees to seek first aid and medical attention for my child. In the event of an emergency, I give permission to the licensed physician chosen by these designees to hospitalize, secure treatment, anesthesia or surgery for the previously listed child.

_____ _____
Parent/Guardian Printed Name Phone

Parent Address:_____ WI _____
Street City State Zip

Parent will attend WIHA Events: YES / NO

_____ _____
Parent/Guardian Signature Date

_____ _____
Emergency Contact/Phone Second Emergency Contact/Phone

_____
Coach/Designee name/address/phone