



**Iron Horse Country Ranch LLC**

**Medical Release 2026**

Parent (Mother) Name/Phone: \_\_\_\_\_

Parent (Father) Name/Phone: \_\_\_\_\_

Child (1) Name: \_\_\_\_\_

Child (2) Name: \_\_\_\_\_

Child (3) Name: \_\_\_\_\_

Email Address: Mother: \_\_\_\_\_ Father: \_\_\_\_\_

Emergency Contact if Different Than Parent:

Name/Relationship/Phone Number: \_\_\_\_\_

In the event of an emergency or non-emergency situation requiring medical treatment,

I, \_\_\_\_\_, hereby grant permission for any and all medical and/or dental attention to be administered to me or my child/children, in the event of an accidental injury or illness, until such time as I can be contacted. This permission includes, but is not limited to, the administration of first aid, the use of an ambulance, and the administration of anesthesia and/or surgery, under the recommendation of qualified medical personnel. By signing this form parents agree that all information is correct and true. Parents assume all risk of injury to themselves or child/children and acknowledge that Iron Horse Country Ranch LLC does not provide medical insurance. Parents are responsible for themselves and child's medical costs.

**Allergy Information (Leave blank if None)**

<i>Child Name</i>	<i>Specific Allergies &amp; Reactions (Type of Plant, Food, Insect, or Medication)</i>	<i>Epi Pen Use? Exp. Date if Yes</i>	<i>Asthma Inhaler? Exp. Date if Yes</i>

**Medications Routinely Taken (Leave blank if None)**

<b>Child Name</b>	<b>Medication</b>	<b>Dose</b>	<b>Frequency</b>	<b>Reason</b>

Parent Printed Name: \_\_\_\_\_ Date \_\_\_\_\_

Parent Signature: \_\_\_\_\_