



Authorization for Emergency Treatment

No individual can participate in any activity of the Therapeutic Equestrian Center until this form has been completed by his/her parent(s)/guardian, or by the individual if he/she is a legally competent adult 18 years of age or over. You are being asked to complete this form to give an appropriate medical facility permission to treat the participant named below for minor injury or medical problems. In the event of serious injury or illness, you will be contacted; treatment will proceed before contacting you only if the situation is urgent and does not permit delay.

PARTICIPANT: Full Name _____ Date of Birth _____
Mailing Address _____
City _____ State _____ Zip _____
Phone (_____) _____ Age _____ Height _____ Weight _____
Diagnosis _____ Date of Onset _____

Is there a medical condition, allergy, etc., requiring special precaution or treatment? Yes No
If yes, please describe: _____

Medications currently being used: Yes No If Yes, please list name, purpose and dosage:

PARENT/GUARDIAN: Full Name: _____ Relationship: _____
Phone (_____) _____
Alternate Phone (_____) _____ Alternate Phone (_____) _____
Mailing Address _____

PHYSICIAN: Name _____ Phone (_____) _____
Address _____

Preferred Medical Facility _____
HEALTH INSURANCE
Name of Policyholder/Relationship to Participant: _____
Policyholder's address _____

Please attach a photocopy of both sides of your insurance card (preferred) OR complete the insurance information requested here.

Name and Address of Insurance
Company _____
Insurance Company Phone Number (_____) _____ **Policy Number** _____

Persons who should be notified in case of emergency:
Name: _____ Relationship: _____ Phone: _____
Name: _____ Relationship: _____ Phone: _____
Name: _____ Relationship: _____ Phone: _____

Authorization for Emergency Medical Treatment

Consent Plan: In the event that emergency medical aid/treatment is required for the above-named due to illness or injury during the process of receiving services, or while present at any activity site of the Therapeutic Equestrian Center, I consent to the Therapeutic Equestrian Center employees, representatives, or agents administering, arranging for, or consenting to the aid of treatment in his/her/their discretion, including the following:

1. Secure and retain medical treatment and transportation if needed.
2. Release any records upon request to the authorized individual or agency involved in the medical emergency treatment.

This authorization includes x-ray and other diagnostic procedures, surgery, hospitalization, medication, and any treatment procedure deemed "life-saving" by the treating physician. This provision will be invoked only if an individual with authority to consent to treatment cannot be contacted timely.

Date: _____ Consent Signature: _____
Above-named Person (if competent adult), Parent or Legal Guardian

Non Consent Plan: I do not give my consent for emergency medical treatment/aid in the case of illness or injury during the process of receiving services or while present at any activity site of the Therapeutic Equestrian Center.

Check one box:

- Parent or legal guardian of the above-named will remain on site at all times during the process of receiving services or while present at any activity site of the Therapeutic Equestrian Center.
- In the event emergency medical aid/treatment is required, I wish the following procedure to take place:

Date: _____ Consent Signature: _____
Above-named Person (if competent adult), Parent or Legal Guardian