



Authorization for Emergency Medical Treatment- Volunteer (Please print clearly.)

Name: _____ Date of Birth: _____ Phone #: _____

Address: _____ City: _____ State: _____ Zip: _____

Physician Name: _____ Preferred Medical Facility: _____

Do You Have Health Insurance? Yes No

Health Insurance Company Name and Phone #: _____

Policy Holder Name: _____ Policy #: _____

Allergies to Medications: _____

Other Allergies: _____

Current Medications: _____

Height: _____ Weight: _____

In the event of an emergency, contact:

Name: _____ Relationship: _____ Phone #: _____

Name: _____ Relationship: _____ Phone #: _____

Name: _____ Relationship: _____ Phone #: _____

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.

Written Name of Parent/Guardian (if applicable)

Consent Signature of Participant or Parent/Guardian

Date

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:

Written Name of Parent/Guardian (if applicable)

Consent Signature of Participant or Parent/Guardian

Date