



Authorization for Emergency Medical Treatment

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 _____
Current Medications _____
Height _____ Weight _____ (program volunteers only)

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.

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