Authorization for Emergency Medical Treatment

○ Participant ○ Staff ○ Volunteer

Name:____________________________________ DOB:________________ Phone: ______________

Address: ____

Physician's Name:_________________________ Preferred Medical Facility:__________________________

Health Insurance Company:______________________ Policy #: ___________________________________

Allergies to Medications:____

Current Medications: ____

In the event of an emergency, contact:

Name:____________________________ Relation:____________ Phone:____________________________

Name:____________________________ Relation:____________ Phone:____________________________

Name:____________________________ Relation:____________ Phone:____________________________

In the event of an emergency medical aid/ treatment is required due ti illness or injury during the process of receiving services, or while being on the property of the agency, I authorize _______________ (Centers Name) to:

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

Consent Plan

This authorization includes x-rays, surgery, hospitalization, medication and any treatment procedure deemed "life saving" by the physician. This provision will only be invoked if the persons above is unable to be rached.

Date:___________ Consent Signature: ____

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 being on the property of the agency.

Parent of legal guardian will remain on site at all times during equine assisted activities

In the event emergency treatment/aid is required I wish the followingprocedure to take place:

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Date:________________ Consent Signature:____