Authorization for Emergency Medical Treatment

Name: _____ DOB: _____ Age: _____

Address: _____ City/State/Zip: _____

Health Insurance Carrier: _____ Policy #: _____

Allergies: _____

Current Medications: _____

Physicians Name: _____ Phone: _____

Preferred Medical Facility: _____

Address: _____ City/State/Zip: _____

Consent Plan

I, (we) _____, the undersigned, parent(s) or legal guardian(s) of _____, do hereby authorize _____ or authorize _____ personnel as agent(s) for the undersigned to consent to any x-ray, examination, anesthetic, medical surgical diagnosis or treatment which is deemed advisable by and is rendered under general or special supervision of any physician, surgeon or dentist licensed under provisions of the medical practice act on the medical staff of any accredited hospital, whether such diagnosis or treatment is rendered at the office of said physician or at the hospital.

It is understood that this authorization is given in advanced of any specific diagnosis, treatment or hospital care being required, but is given to provide authority and power on the part of aforesaid agent(s).

In the event that emergency medical aid/treatment is required due to illness or injury during the process of receiving services, or while being on the property of _____, at _____.

I, _____ authorize _____ to secure and retain medical treatment and transportation if needed.

Consent Signature: _____ 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 being on the property of _____, at _____. A

Parent / Legal Guardian will remain on site at all times during equine assisted activities. In the event of emergency treatment/aid is required, I wish the following procedure to take place: _____

_____

_____.

Non-Consent Signature: _____ Date: _____