



## Authorization For Emergency Medical Treatment

<b>Check one:</b>	<input type="checkbox"/> Client	<input type="checkbox"/> Volunteer	<input type="checkbox"/> Staff
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Name (of Client, Volunteer or Staff Member) \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Preferred Medical Facility \_\_\_\_\_

Physician's Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Health Insurance Co. \_\_\_\_\_ Policy #: \_\_\_\_\_

### Emergency Info:

Contact Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Phone #: \_\_\_\_\_

Contact Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Phone #: \_\_\_\_\_

Allergies to Medications \_\_\_\_\_

Current Medications: \_\_\_\_\_

In the event emergency medical aid/treatment is required due to illness or injury during the process of receiving services, volunteering, or while being on the property of the agency, I hereby authorize Horseplay Therapeutic Riding Program, Inc. to: 1. Secure and retain medical treatment and transportation if needed; 2. Release client or volunteer records upon request to the authorized individual or agency involved in the medical emergency treatment.

**CONSENT PLAN (Parents/legal guardians must sign for children under 18 or for wards of the court)**

This authorization includes x-ray, surgery, hospitalization, medication and any treatment procedure deemed "life-saving" by the physician. This provision will only be invoked if the person below is unable to be reached.

Printed Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Consent Signature  
 (Participant, Parent or Guardian) \_\_\_\_\_ Date: \_\_\_\_\_

Address \_\_\_\_\_

**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, volunteering, or while being on the property of the agency. In the event emergency aid/treatment is required, I wish the following procedures to take place (If you choose this plan, you must fill in some specifics for the aid which you will/will not allow):

Signature: \_\_\_\_\_ Print Name: \_\_\_\_\_ Date: \_\_\_\_\_  
 (Client/ Parent/legal guardian must sign for children under 18 or wards of the court.)

Signature of Parent/Guardian: \_\_\_\_\_ Print Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address \_\_\_\_\_

*A copy of the completed Medical Form or Health History should be attached to this form.*