Authorization for Emergency Medical Treatment Form

Name:_____ DOB:_____ Phone:_____

Address:_____

Nature of disability:_____

Physician's Name:_____ Phone:_____

Preferred Medical Facility:_____

Health Insurance Co:_____ Policy #:_____

Allergies to Medication:_____

Current Medications:_____

Date of last Tetanus Shot:_____

The rider is currently independently covered by his or her own accident/medical insurance
and will remain insured for the duration of all programs at Hooves to Heal, NFP.   _____

Initials

In the event of an emergency, contact:

Name:_____ Relation:_____ Phone:_____

Name:_____ Relation:_____ Phone:_____

Name:_____ Relation:_____ Phone:_____

In the event emergency medical aid/treatment is required due to illness or injury during the process of receiving services, or while being on the property of the agency, I authorize Hooves to Heal, NFP 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 person(s) above are unable to be reached.

Date:_____ Consent Signature:_____

Participant, Parent or Legal Guardian
Signed in presence of center staff

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. A parent or legal guardian will remain on site at all times during equine assisted activities.

In the event emergency treatment/aid is required, I wish the following procedures to take place:
_____
_____

I understand and agree that under no circumstances shall Hooves to Heal, NFP, their respective members, Board of Directors, managers, directors, agents, instructors, employees, therapists, property owners, and horse owners be liable for any damages, injury, or other loss, resulting from or in connection with the provision of such care.

Date:_____ Consent Signature:_____

Participant, Parent or Legal Guardian
Signed in presence of center staff

~ Participant ~ Staff ~ Volunteer~