

# Authorization for Emergency Medical Treatment Form

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 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 \_\_\_\_\_ 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-ray, surgery, hospitalization, medication and any treatment procedure deemed "life saving" by the physician. This provision will only be invoked if the person(s) above is unable to be reached.

Date: \_\_\_\_\_ Consent Signature: \_\_\_\_\_  
Client, 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 being on the property of the agency.

- 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 procedure to take place:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Date: \_\_\_\_\_ Consent Signature: \_\_\_\_\_  
Client, Parent or Legal Guardian