Horses with Hearts, Inc.
Therapeutic Riding
PO Box 2186, Martinsburg, WV, 25402

Authorization for Emergency Medical Treatment Form

Circle One: 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, please 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:
(Center's Name)

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
Signed in presence of center staff

Non-Consent Plan

I do not 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: _____ Rev 2/19/2013
Client, Parent or Legal Guardian
Signed in presence of center staff