Emergency Treatment Authorization Form

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 name)

1. Administer emergency treatment.
2. Secure and retain medical treatment and transportation if needed.
3. Release personal records upon request to the authorized individual or agency involved in the medical emergency treatment.

Name: _____DOB: _____ Phone: _____

Address: _____

If under 18 years old:

Mother's Name: _____ Father's Name:_____

Mother's Work # _____Cell:_____Father's Work # _____Cell: _____

Legal Guardian's Name: _____Work #_____Cell: _____

In the event a parent/guardian cannot be reached, contact: _____Phone: _____

Physician's Name: _____ Preferred Medical Facility: _____

Health Insurance Co._____ Policy #: _____

Allergies: _____Inhaler: Yes or No

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 person(s) above are unable to be reached. Date: _____ Consent Signature: _____

Participant, Staff, Vol, Visitor, Parent/ Guardian if under 18

Print Name:_____ Phone: _____

Address: _____

Non Consent

I do not consent to having the equine center seek any medical treatment.

Date: _____ Consent Signature: _____

Participant, Staff, Vol, Visitor, Parent/ Guardian if under 18

A PARENT/GUARDIAN IS REQUIRED TO REMAIN ON GTRC PROPERTY AT ALL TIMES FOR PARTICIPANTS UNDER 18 OR THOSE UNABLE OF MAKING LEGAL DECISIONS ON THEIR OWN.