Reining Hope Adaptive Equine Assisted Activities & Therapies LLC

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"Wish It, Dream It, Do It!"

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

_______Participant _______Staff _______Volunteer

Name: ______________________________________ DOB: __________ Phone: ___________________________
Physician's Name: _________________________________ Preferred Medical Facility: ____________________
Health Insurance Co: ______________________________ Policy #: ____________________________________
Current Allergies, Medications and Health Concerns: ____

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In the event of an emergency:
Emergency Contact 1: ____ Relation: _______________________
Home Ph: ________________________Work Ph: ____________________ Cell Ph: ______________________
Emergency Contact 2: ____ Relation: _______________________
Home Ph: ________________________ Work Ph: ____________________ Cell Ph: ______________________

In the event that an 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 REINING HOPE AEAAT LLC 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) listed as emergency contact(s) cannot be reached.**

Date: __________________ Consent Signature: ____
Client, Parent or Legal Guardian

NON-CONSENT PLAN
I do not give 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. In the event emergency treatment/aid is required, I wish the following procedures to take place (please give details below):

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Date: _________________ Non-Consent Signature: ____
Client, Parent or Legal Guardian