Authorization for Emergency Medical Treatment Form

❑ Participant

❑ Staff

❑ Volunteer

Name: _____ DOB: _____

Address:

_____

Physician's Name: _____

Health Insurance Company: _____

Allergies to medications:

_____

Current medications:

_____

In the event of an emergency contact:

Name: _____ Relation: _____

Phone: _____

Name: _____ Relation: _____

Phone: _____

Name: _____ Relation: _____

Phone: _____

Consent Plan

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 Restoration Ranch, LLC and its representatives 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 medical emergency treatment.

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

Phone: _____

Preferred Medical Facility: _____

Policy # _____

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:

_____

_____

_____

_____

Non-Consent Signature: _____

Client, Parent or Legal Guardian

Signed in presence of center staff

Date: _____