



Horseplay Therapeutic Riding Program, Inc.
A 501(c)(3) Non-profit Organization
www.horseplaytherapy.org

Authorization For Emergency Medical Treatment

Check one:	Client	Volunteer	Staff
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Name _____ Date of Birth: _____

Address: _____ Phone: _____

Preferred Medical Facility _____

Physician's Name: _____ Phone: _____

Health Insurance Co. _____ Policy #: _____

Emergency Info:

Contact Name: _____ Relation: _____ Phone #: _____

Contact Name: _____ Relation: _____ Phone #: _____

Allergies to Medications _____

Current Medications: _____

In the event emergency medical aid/treatment is required due to illness or injury during the process of receiving services, volunteering, or while being on the property of the agency, I hereby authorize Horseplay Therapeutic Riding Program, Inc. to: 1. Secure and retain medical treatment and transportation if needed; 2. Release client or volunteer records upon request to the authorized individual or agency involved in the medical emergency treatment.

CONSENT PLAN (Parents/legal guardians must sign for children under 18 or for wards of the court)

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 below is unable to be reached.

Printed Name: _____ Phone: _____

Consent Signature
 (Participant, Parent or Guardian) _____ Date: _____

Address _____

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, volunteering, or while being on the property of the agency. In the event emergency aid/treatment is required, I wish the following procedures to take place (If you choose this plan, you must fill in some specifics for the aid which you will/will not allow):

Signature: _____ Print Name: _____ Date: _____
(Client/ Parent/legal guardian must sign for children under 18 or wards of the court.)

Signature of Parent/Guardian: _____ Print Name: _____ Date: _____

Address _____

A copy of the completed Medical Form or Health History should be attached to this form.