Emergency Contacts and Authorization for Emergency Medical Treatment

Participant_____ Date_____

In the event emergency medical aid or treatment is required due to illness or injury during the process of receiving services or aiding in providing services at Fair Hill Therapeutic Riding Center, I authorize FHTRC to:

1. Secure and retain medical treatment and transportation if needed.

2. Release medical records upon request to the authorized individual or agency involved in the medical emergency treatment.

Emergency contact _____Home Phone _____

Cell Phone _____

Physician's name _____Phone _____

Preferred Medical Facility _____

Health Insurance Co _____Policy#_____

Please check one

___Consent Plan: This authorization includes x-ray, surgery, hospitalization, medication and any treatment procedure deemed "lifesaving" by the physician. This provision will only be invoked if the person listed above is unable to be reached.

___Non-Consent Plan: I do not give my consent for emergency medical treatment or aid in the case of illness or injury during the process of receiving or aiding in providing services at FHTRC

Date: _____ Consent Signature _____

(Parent or guardian if under 18)

Date: _____ Non-Consent Signature_____

(Parent or guardian if under 18)

Print Name: _____

Staff initial_____ Date received_____