HORSES & HORIZONS
Therapeutic Learning Center, Inc.
375 Zion's Stone Church Rd., New Ringgold, PA 17960

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT FORM

Check One: __ Participant __ Staff __ Volunteer

Name _____ DOB ___/___/___ Phone _____

Address _____

Physician's Name _____ Preferred Medical Facility _____

Health Insurance Company _____ Policy # _____

Allergies to Medications _____

Current Medications _____

In the event of an emergency, contact:

Name _____ Relation _____ Phone _____

Name _____ Relation _____ Phone _____

Name _____ Relation _____ Phone _____

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 Horses & Horizons Therapeutic Learning Center, Inc. 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) above cannot be reached.

Date ___/___/___ Consent Signature _____

Client, Volunteer, Parent or Legal Guardian

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:

_____

_____

_____

Date ___/___/___ Non-Consent Signature _____

Client, Volunteer, Parent or Legal Guardian