

Date filled out: \_\_\_\_\_

**HORSE  
N'  
BUDDY**



### EMERGENCY MEDICAL TREATMENT

Student Name: \_\_\_\_\_ DOB: \_\_\_\_\_

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: \_\_\_\_\_

### PLEASE SIGN ONE OF THE TWO FOLLOWING BOXES

#### 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 Horse n' Buddy 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

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.

Consent Signature: \_\_\_\_\_ Date: \_\_\_\_\_

*Client, Parent or Legal Guardian (please indicate which of these is relevant)*

This document to be counter-signed by center staff.

Staff Signature: \_\_\_\_\_ Date: \_\_\_\_\_

#### 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 of 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 procedures to take place:

\_\_\_\_\_  
\_\_\_\_\_