

Date filled out: _____



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 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 procedures to take place:

