JAF's THERAPY IN MOTION

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AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

Participant ☐ Staff ☐ Volunteer ☐

Name_____DOB_____Phone_____

Address_____City_____

Physician's Name_____Preferred Medical Facility_____

Health Insurance Co._____Policy #_____

Allergies to Medications_____

Current Medications_____

In the event of an emergency, contact

Name_____Relation_____Phone_____

Name_____Relation_____Phone_____

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 **JAF's Therapy in Motion**, I authorize **JAF's Therapy in Motion, Inc.** and **any of its representatives** 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.

Date:_____ Consent Signature:_____
Client, Parent, or Legal Guardian, *Signed in presence of center staff*

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 **JAF's Therapy in Motion, Inc**.

In the event emergency treatment/aid is required, I wish the following procedure to take place:

_____

_____

Date:_____ Non-Consent Signature:_____
Client, Parent, or Legal Guardian, *Signed in presence of center staff*

A COPY OF THE COMPLETED MEDICAL HISTORY SHOULD BE ATTACHED TO THIS FORM

PATH INTERNATIONAL
Professional Association of Therapeutic Horsemanship International