



SHERLOCK FARMS

Where Horses Give Us Wings

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

(Must be completed by parent/guardian if under 18 or unable to sign legal documents)

Name: _____ DOB: _____

Home Phone: _____ Cell Phone: _____

Address: _____

Physician: _____ Preferred Medical Facility: _____

Health Insurance Co.: _____ Policy Number: _____

Allergies to Medications: _____

Current Medications: _____

In the event of an emergency, contact:

1. Name: _____ Relation: _____ Phone: _____

2. Name: _____ Relation: _____ Phone: _____

Consent Plan

In the event emergency medical aid/treatment is required due to illness or injury while participating in a program of Sherlock Farms, I authorize Sherlock Farms Therapeutic Riding to:

1. Secure and retain medical treatment and transportation as deemed necessary.
2. Release appropriate records to the authorized individual/agency involved in the medical emergency treatment.

This authorization includes medical imaging, surgery, hospitalization, medication and any treatment procedure deemed "life saving" by a physician. This provision will only be invoked if a person above is unable to be reached.

Consent Signature (Signed in presence of SFTR rep)

Date

Non-consent Plan

I **do not** give my consent for emergency medical treatment in the event of illness or injury while participating in a program of Sherlock Farms. I agree that a parent or legal representative will remain on site all times during equine assisted activities. In the event emergency treatment or first aid is required, I wish the following procedures to take place:

Non-consent Signature (Signed in presence of SFTR rep)

Date