MANE STRIDE

An Equine Assisted Therapeutic and Riding Program

Authorization for Emergency Medical Treatment Form

□ 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: _____

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 MANE STRIDE 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 treatment procedure deemed "life saving" by the physician. This provision will only be involved 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 the agency.

□ Parent or legal guardian will remain on site at all times during the equine assisted activity.

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

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