Describe any past medical conditions which might require special attention (if none, please indicate):_____

Are you on medication? _____
What? (please list)_____

The Health History is for the health care concerns at the specified event only. All records will be handled by staff/volunteers, whose job includes processing or using this information for the benefit of the participant. All medical records will be held in limited access by the health care supervisor of the specific event. Minimal necessary information may be shared with event staff volunteers in order to provide adequate participant safety and health care. The health form will be retained by The Whole Horse Place until it is destroyed. All forms with noted treatment will be retained for seven years past the age of maturity of the participant. Access to the information will be limited, but copies may be requested from the event sponsor, by the participant, or their legal representative. I have read the above procedures for handling the health form information, and I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes.

This health history is complete and accurate. I give permission to engage in all prescribed activities, except as noted.

Signature of parent or guardian: _____ **Date:**_____

Authorization for Emergency Treatment

All information is confidential.

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 program or the property of Alpine Evergreen, I authorize The Whole Horse Place, Inc. 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 medical emergency treatment.

Consent Plan

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) listed above is unable to be reached.

Date:_____ Consent Signature:_____

Non-consent Plan

I do not give my consent for emergency medical treatment for illness or injury during the process of receiving services or while being on the property of the agency. In the event emergency treatment is required, I wish the following:

Date:_____ Consent Signature:_____