FRESNO HIPPOTHERAPY

Authorization for
Emergency Medical Treatment

print PARTICIPANT'S NAME_____ DATE OF BIRTH_____
print PARENT/GUARDIAN NAME (if applicable)_____
ADDRESS_____
CITY_____STATE_____ZIP CODE_____
PHONE # (home)_____ (work)_____
IN THE EVENT OF AN EMERGENCY, CONTACT:
NAME_____ PHONE #_____
NAME_____ PHONE #_____
PHYSICIAN'S NAME_____ PHONE #_____
PREFERRED MEDICAL FACILITY_____ PHONE #_____
HEALTH INSURANCE CO._____POLICY # _____

List all pertinent medical information (allergies to food or drugs, medication being taken, special medical considerations):_____
_____

CONSENT PLAN

In the event emergency aid/treatment is required due to illness or injury during the process of providing and/or receiving services, or while being on the property of Fresno Hippotherapy, I authorize the Fresno Hippotherapy representative to:

1. Secure and retain medical treatment and transportation if needed.
2. Release 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) listed is unable to be reached.

DATE_____CONSENT SIGNATURE_____
Print NAME_____ RELATIONSHIP_____

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 providing and/or receiving services or while being on the property of Fresno Hippotherapy. In the event emergency treatment/aid is required, I wish the following procedures to take place:

_____
_____
_____
_____

DATE_____CONSENT SIGNATURE_____
Print NAME_____ RELATIONSHIP_____