Blu Flame Horsemanship

Authorization for Emergency Medical Treatment Form

_____Participant _____Staff _____Volunteer

Name: _____ DOB:_____ Phone:_____

Address:_____

Physician's Name:_____ 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 the agency, I authorize Blu Flame Horsemanship 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 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 equine assisted activities

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

_____

_____

_____

Date: _____ Non-Consent Signature: _____

Client, Parent or Legal Guardian Signed in presence of staff.