HEALTH DIRECTED RIDING, INC.

Where Rehab Reins

Authorization for Emergency Medical Treatment

Authorization for Emergency Medical Treatment Form

_____Participant _____Staff _____Volunteer

Name:_____ DOB:_____ Phone:_____
Address:_____
Physician's Name: _____ Medical Facility: _____
Health Insurance Company: _____ Policy #: _____
Allergies to medications: _____
Current medications: _____

In the event of an emergency, contact:
Name:_____Relationship: _____ Phone:_____
Name:_____Relationship: _____ Phone:_____
Name:_____Relationship: _____ Phone:_____

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 Health Directed Riding, 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 the 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) above is unable to be reached.

Date:_____Consent Signature:_____
Client, Parent or Legal Guardian
Signed in presence of the 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 on the agency. In the event emergency treatment/aid is required, I wish the following procedures to take place:

Date:_____Consent Signature:_____
Client, Parent or Legal Guardian
Signed in presence of the center staff

ATTACH A COPY OF THE COMPETED MEDICAL/HEALTH HISTORY TO THIS FORM