Ponies As Partners - Therapeutic Riding, Inc.

A Non-Profit Organization

516 Third Beach Road Middletown, RI 02842 (401) 683-9437

Authorization for Emergency Medical Treatment Form

^ Participant ^ Staff ^ Volunteer

Name: _____ DOB: _____

Phone:_____

Address:

_____

Physician's Name: _____ Phone:_____

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: _____

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 Ponies As Partners, 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

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. 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

All of the information on this form applies.

Signature:_____ Date: _____

Signature:_____ Date: _____

Signature:_____ Date: _____