

Reins From Above Therapeutic Riding Center, Inc.

86 Polenta Road
Smithfield, NC 27577
Phone: 919-938-1556

Website: www.reinsfromabove.org

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT FORM

Check one: ___ Participant ___ Volunteer ___ Staff

Date: _____ Email Address: _____

Name (of Participant, Volunteer or Staff Member): _____ Date of Birth: _____

Address: _____ Phone: _____

Preferred Medical Facility _____

Physician's Name: _____ Phone: _____

Health Insurance Co.: _____ Policy # _____

Emergency Contacts:

Name: _____ Relation: _____ Phone: _____

Name: _____ Relation: _____ Phone: _____

Allergies to Medications: _____

Current Medications: _____

In the event emergency medical aid/treatment is required due to illness or injury during the process of receiving services, volunteering, or while being on the property of the agency, I hereby authorize **Reins From Above Therapeutic Riding Center, Inc.** to:

1. Secure and retain medical treatment and transportation if needed.
2. Release client or volunteer records upon request to the authorized individual or agency involved in the emergency medical treatment.

CONSENT PLAN (Parents/legal guardians must sign for children under 18 or for wards of the court)

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 below is unable to be reached.

Date: _____ Consent Signature: _____

Print Name: _____

Phone: _____ Address: _____

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, volunteering, or while being on the property of the agency. In the event emergency aid/treatment is required, I wish the following procedures to take place (If you choose this plan, you must fill in some specifics for the aid which you will/will not allow):

Date: _____ Non-Consent Signature: _____

Print Name: _____

Phone: _____ Address: _____

A copy of the completed Medical Form or Health History should be attached to this form.