



Authorization for Emergency Medical Treatment Form

Participant Staff Volunteer

Name: _____ DOB: _____ Phone: _____

Address: _____

Physician's Name: _____ 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: _____

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 GAITS OF FREEDOM 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 center staff)

Non-Consent Plan

I do not give my consent for emergency medical treatment/aid in the case if illness or injury during the process of receiving services from GAITS OF FREEDOM or while being on the property of FAIRVIEW FARMS JJC Ltd.

- 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 to take place:

Date: _____ Non-Consent Signature: _____
Client, Parent or Legal Guardian (signed in presence of center staff)