



# HOPE Therapeutic Riding Center

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Website: [www.hope-whidbey.org](http://www.hope-whidbey.org)

## AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

PLEASE CHECK ONE:  STAFF  STUDENT  VOLUNTEER

[PLEASE PRINT OR TYPE]

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City/Zip: \_\_\_\_\_

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 property used by HOPE Therapeutic Riding Center ("HOPE"), I authorize HOPE to:

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

This authorization includes x-ray, surgery, hospitalization, medication and any procedure deemed "life saving" by the health care provider. **This provision will only be invoked if HOPE is unable to reach an emergency contact listed above.**

Date: \_\_\_\_\_ Consent Signature: \_\_\_\_\_

(Adult Student, 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 property used by HOPE. I understand that: **(please check one)**

- A 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: \_\_\_\_\_

(Adult Student, Parent or Legal Guardian)