



HOPE Therapeutic Riding Center

P.O. Box 334, Langley, WA 98260 (360) 221-7656

Email: hope@whidbey.com

Website: 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)