



## Emergency Medical Treatment Consent Form

### 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 Hunters Edge Equestrian Center 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 below is unable to be reached.

In the event I \_\_\_\_\_ cannot be reached, please  
Parent or Guardian

Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

Physician's Name: \_\_\_\_\_

Preferred Medical Facility: \_\_\_\_\_

Health insurance Co.: Policy #: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(Parent or Guardian)

Print Name: \_\_\_\_\_ Phone: \_\_\_\_\_

### 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:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(Parent or Guardian)

Print Name: \_\_\_\_\_ Phone: \_\_\_\_\_