Authorization for Emergency Medical Treatment

CONSENT PLAN

In the event emergency medical aid/treatment is required due to illness or injury while participating in the Prospect Riding Center program: I authorize Prospect Riding Center to secure and retain medical treatment and transportation if needed. This authorization includes but is not limited to x-ray, surgery, hospitalization, medication and any treatment deemed "life-saving" by the physician. In addition, I authorized Prospect Riding Center to release my records to any individual involved in medical treatment and/or transportation I might need. This provision will be invoked only if the emergency contact person(s) listed below is/are unable to be reached.

Date: _____ Participant's Name (print) _____DOB: _____
Home Phone Number: (____) _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

In case of emergency, contact:

Name: _____Relationship: _____ Phone Number(s): (____) _____

Name: _____Relationship: _____ Phone Number(s): (____) _____

Physician's Name: _____ Phone Number: (____) _____
Preferred Medical Facility:
_____
Allergies to Medications:
_____
Current Medications:
_____

_____

Health Insurance Company: _____

Policy Number: _____
Consent Authorized Signature _____ _____ Date:_____
(Parent / Legal Guardian/Participant if over 18)

NON-CONSENT PLAN

I do not give my consent for emergency medical treatment in the case of illness or injury while participating in the Prospect Riding Center program. In the event of emergency treatment aid is required, I wish the following procedures to take place: (list procedures)_____
_____
_____
_____
Date: _____ Participant's Name (print):
_____

Parent or Legal Guardian will remain on site at all times during equine assisted activities.

Non-Consent Authorized Signature: _____Date: _____
(Parent / Legal Guardian / Participant if over 18)