

Columbia - Greene Therapeutic Riding Center, Inc.
P.O. Box 302 831 Mail Route Road
Ashland, N.Y. 12407
518-734-4445

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: _____

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 _____ to:

(Center's Name)

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.

Consent Plan

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 of illness or injury during the process of receiving services or while being on the property of the agency.

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: _____ Consent Signature: _____

Client, Parent or Legal Guardian
Signed in presence of center staff