Equi ★Star Therapeutic Riding Center, Inc.

PO Box 25, 2199 Fuller Road, Burt NY 14028 716-778-8249

2012 RIDER AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

In the event that 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 Equi★Star Therapeutic Riding Center, Inc. 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.

Rider's Name	DOB	Age
Address, City, Zip	Home Phone:	
Email address:	Cell Phone:	
In the event that I can not be reached, contact:	Contact #1 Phone	
In the event that I can not be reached and a second contact is needed:	Contact #2 Phone	
Physicians Name	Physician's Phone	
Preferred Medical Facility		
Health Insurance Co.	Policy #	

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 below is unable to be reached.

________________________ ____
Date Consent Signature of Client, Parent or Guardian Signature

____ ________________________
(Print Name) (Print Phone)

Address____

City_______________________________________ Zip _________________________

over →

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:

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__________________________ ____
Date Non-Consent Signature of Client, Parent or Guardian Signature

____ ________________________
(Print Name) (Print Phone)

Address____

City____ Zip ___________________________

A COPY OF THE COMPLETED MEDICAL HISTORY SHOULD BE ATTACHED TO THIS FORM

12/30/2011