



**Equi★Star Therapeutic Riding Center, Inc.**

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

**2011 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		Physicians 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 \_\_\_\_\_

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