EAST CENTRAL INDIANA
Therapeutic Riding, Inc.
Contact: Elise Matthews
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Muncie, IN 47304
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# Authorization for Emergency Medical Treatment Form

☐ **Participant** ☐ **Staff** ☐ **Volunteer**

Name:_____ DOB:_____ Phone_____

Address:_____

Physician's Name:_____ Medical Facility:_____

Health Insurance Company:_____ Policy #:_____

Allergies to Medications:_____

Current Medications:_____

In the event of an emergency, contact:

Name:_____ Relationship:_____ Phone:_____

Name:_____ Relationship:_____ Phone:_____

Name:_____ Relationship:_____ 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 Whispering Pines 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.

**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/are unable to be reached.

Date:_____ Consent Signature:_____

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

**A COPY OF THE COMPLETED MEDICAL /HEALTH HISTORY SHOULD BE ATTACHED TO THIS FORM.**

EAST CENTRAL INDIANA

# Therapeutic Riding, Inc.

**NON-CONSENT PLAN**

I do not give my consent for emergency medical treatment/aid in the case if illness or injury during the process of receiving services or while being on the property of the agency. In the event emergency treatment is required, I wish the following procedures to take place:

Date:_____ Consent Signature:_____

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

**A COPY OF THE COMPLETED MEDICAL /HEALTH HISTORY SHOULD BE ATTACHED TO THIS FORM.**