AUTHORIZATIONS FOR EMERGENCY MEDICAL TREATMENT FORM

Name: _____

Physician's Name: _____ Phone Number: _____

In the event of an emergency, contact:

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

In the event emergency medical aid or 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 Cross Creek Meadows Therapy Riding Center to:

1. Secure and retain medical treatment and transportation if needed.
2. Release my 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.

Signature: _____ Date: _____

If under 18 years of age, Parent/Guardian Signature _____

Non-Consent Plan

I do not give consent for emergency medical treatment/aid in the event of illness or injury during the process of receiving services, any participation on my part at Cross Creek Meadows, or while being on the property of Cross Creek Meadows Therapeutic Riding Center. In the event emergency treatment/aid is required, I wish the following procedures to take place:

_____

_____

_____

Participant's Signature _____ Date: _____

Signature of Parent/Guardian _____

(If participant is under 18 years of age)