



**Mounted Angels Therapeutic
Horsemanship**
10362 465th St. Pearl, IL 62361
217-829-4409-home 217-257-5702 cell

*A Spirit
Horse
Member
Center*

Authorization for Emergency Medical Treatment Form

____ Participant ____ Staff ____ Volunteer
Name: _____ DOB: _____
Phone Numbers: _____
Address: _____

Physician's Name: _____ Preferred Medical Facility: _____

Health Insurance Company _____ Policy Number _____

Allergies to medications: _____

Current Medications: _____

In the event of an emergency contact:

Name _____	Relation _____	Phone _____
Name _____	Relation _____	Phone _____
Name _____	Relation _____	Phone _____

Sign only one plan below.

Consent Plan

In the event emergency medical treatment/aid is required due to illness or injury while at a Mounted Angels session, I authorize Mounted Angels to:

1. Secure and retain medical treatment and transportation if needed.
2. Release participant/volunteer records upon request to the authorized individual or agency involved in the medical emergency treatment.

This authorization includes x-ray, surgery, hospitalization, medication and any treatment deemed "life saving" by the physician. This provision will only be invoked if the emergency contact named above cannot be reached.

Consent Signature: _____ Date: _____
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 a Mounted Angels session and

____ Parent or guardian will remain on site at all times during a Mounted Angels session.

____ In the event emergency treatment/aid is required, I wish the following to take place:

Non-Consent

Signature: _____ Date: _____

Signed in presence of center staff