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