Galloping Acres Foundation, INC

Rider's Authorization for Emergency Medical Treatment Form

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, _____, hereby authorize Galloping Acres Foundation, INC Therapeutic Riding 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.

Client's Name: _____DOB: _____ Age: _____
Address: _____
City/State/Zip: _____ Telephone: _____

IN THE EVENT I AM UNCONSCIOUS AND UNABLE TO ACT FOR MYSELF, CONTACT,

Name: _____ Telephone: _____
Relationship: _____
Physician's Name: _____ Phone: _____
Preferred Medical Facility: _____ Phone: _____
Health Insurance Co.: _____ Policy #: _____

In an effort to provide the best care possible, please indicate below if any of the following apply:

ڤ I am allergic to the following: _____
ڤ I have the following ongoing medical conditions: _____
_____
ڤ I have been treated recently for the following physical/mental condition: _____
_____
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.
Consent Signature: _____ Date: _____
(Client, Parent or Guardian – if under 18)
Print Name: _____Phone: _____

Non-Consent Plan

I, _____, do not give my consent for emergency medical aid/treatment in the case of illness or injury during the process of receiving services while being on the property of the Galloping Acres Foundation, INC. I fully release the center and/or its representatives for any injuries/losses I may incur as a result of this non-consent. In the event emergency aid/treatment is required, I wish the following procedures to take place:
_____
_____
Non-Consent Signature: _____ Date: _____
(Client, Parent or Guardian – if under 18)
Print Name: _____Phone: _____

A COPY OF THE COMPLETED MEDICAL HISTORY SHOULD BE ATTATCHED TO THIS FORM. **(**1/07)