Galloping Acres Foundation, INC AUTHORIZATION FOR EMERGENCY AND MEDICAL TREATMENT

Volunteer and Personnel

In the event emergency medical aid/treatment is required due to illness or injury during the course of Volunteering with the Galloping Acres, Foundation, INC Therapeutic Riding Center, either on said center site or with an off-site activity and/or competition, I, _____, hereby authorize the Galloping Acres Foundation, INC Therapeutic Riding Center to: 1. Secure and retain treatment and transportation if needed.
2. Release all relevant records upon request to the authorized individual or agency involved in the medical emergency treatment.

Name: _____Age: _____DOB: _____
Address: _____
City/State/Zip: _____Telephone: _____

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

Name: _____ Telephone: _____
Relationship: _____
Physician's Name: _____ Telephone: _____
Medical Facility: _____ Telephone: _____
Health Insurance Co: _____ Telephone: _____
Policy Numbers: _____

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

ﷺI am allergic to the following: _____
ﷺI have the following ongoing medical conditions: _____
_____
ﷺI have been treated recently for the following physical/mental conditions: _____
_____
ﷺI am on the following medications: _____
_____

This authorization includes x-ray, surgery, hospitalization, medication, and any treatment procedure deemed "like saving" by the physician. The provision will only be invoked if the person above is unable to be reached.
Date: _____ Consent Signature: _____

Consent Signature: _____
(Parent/Guardian ~ if Volunteer under 18)

~~~~~~~NON-CONSENT FOR MEDICAL TREATMENT AUTHORIZATION ~~~~~~~

I, _____, **NO NOT** give my consent for emergence medical treatment/aid in the case of illness or injury during the course of volunteering or while being on the premises of the Galloping Acres Foundation, INC Therapeutic Riding Center. I gully release the center and/or its representatives for any injuries/losses I may incur as a result of this non-consent. In the event emergence treatment/aid is required, I wish the following procedures to take place: _____
_____
_____

Date: _____Non-Consent Signature: _____

Non-Consent Signature: _____
(Parent/Guardian ~ if Volunteer under 18) (1/07)