THERAPEUTIC AND RECREATIONAL RIDING CENTER, INC.

Authorization for Emergency Medical Treatment

Participant's Name: ___________________________________ DOB: __________ Phone: __________________

Address: ____

Primary Physician Name: ____ Phone # _________________________

Preferred Medical Facility: ____

Health Insurance Co.: ____ Policy # __________________________

Allergies to medications: ____

Current medications: ____

In the event of an emergency, contact:

Name: __________________________________ Relationship: __________________ Phone #: ________________

Alt. Phone #: _____________________________

Name: __________________________________ Relationship: __________________ Phone #: ________________

Alt. Phone #: _____________________________

CONSENT PLAN: In the event emergency medical aid or treatment is required due to illness or injury while receiving services or while on the property of TRRC, Inc., I authorize TRRC, Inc. to:

1. Secure and retain medical treatment and transportation as needed.
2. Release client records upon request to authorized individual or agency involved in medical emergency treatment.

This authorization includes x-ray, surgery, hospitalization, medication, and any treatment procedure deemed "life saving" by the physician or emergency personnel. This provision will only be invoked if the person(s) above is unable to be reached:

Consent Signature: ____ Date: __________________

Participant, Parent or Legal Guardian
Signed in presence of Center staff

Printed Name of Above: ____ Phone # _______________________

NON-CONSENT PLAN: I do not give my consent for emergency medical treatment/aid in the case of illness or injury while receiving services or while on the property of TRRC, Inc.

___ Parent, legal guardian or caretaker will remain on site at all times during equine assisted activities

___ In the event emergency treatment/aid is required, I wish alternate procedures to take place:

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Non-Consent Signature: ____ Date: ________________

Participant, Parent or Legal Guardian
Signed in presence of Center staff

Printed Name of Above: ____ Phone # _____________________

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