



**Horses Unlimited, Inc.**  
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HorsesUnlimited.Inc@gmail.com

*A Charitable Organization  
Providing Therapeutic  
Horseback Riding For  
People With Special Needs*

## **Volunteer Authorization for Emergency Medical Treatment**

In the event emergency medical aid/treatment is required due to illness or injury during the process of receiving services, or while being on property of the agency, I authorize Horses Unlimited, Inc. to secure and retain medical treatment and transportation if needed.

Volunteer's Name \_\_\_\_\_ Phone \_\_\_\_\_  
Address \_\_\_\_\_  
Email \_\_\_\_\_

In the event that I cannot be reached, Contact \_\_\_\_\_ Phone \_\_\_\_\_  
Contact \_\_\_\_\_ Phone \_\_\_\_\_

Physician's Name \_\_\_\_\_ Phone \_\_\_\_\_  
Preferred Medical Facility \_\_\_\_\_ Phone \_\_\_\_\_  
Health Ins. Co. \_\_\_\_\_ Policy # \_\_\_\_\_

### **Consent Plan**

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.

Date \_\_\_\_\_ Consent Signature \_\_\_\_\_  
(Volunteer)

Date \_\_\_\_\_ Consent Signature \_\_\_\_\_  
(Parent Signature)

Print Name \_\_\_\_\_ Phone \_\_\_\_\_  
Address \_\_\_\_\_

### **Non-Consent Plan**

I do not give my consent for emergency medical treatment aid in the case of illness or injury during the process of receiving services or while being on the property of the agency. In the event emergency treatment aid is required, I wish the following procedures to take place:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Date \_\_\_\_\_ Non-Consent Signature \_\_\_\_\_  
(Volunteer)

Date \_\_\_\_\_ Non-Consent Signature \_\_\_\_\_  
(Parent Signature)

Print Name \_\_\_\_\_ Phone \_\_\_\_\_  
Address \_\_\_\_\_