Horses Unlimited, Inc.
PO Box 30194 Cromberg, CA 96103
therapy@horsesui.org
530-280-1565
horsesUI.org
A charitable organization providing therapeutic horseback riding for people with disabilities

Volunteer 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 authorize Horses Unlimited, Inc, to secure and retain medical treatment and transportation if needed.

Volunteer's Name_____Phone_____
Address_____ City_____State_____ ZIP_____
Email_____
Emergency Contacts:
Name_____Phone_____
Name_____Phone_____
Physician's Name_____ Phone_____
Preferred Medical Facility_____Phone_____
Medical Ins. Co._____ Policy #_____

1) 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.

Consent Signature _____ Date _____
(Volunteer)
Consent Signature_____ Date_____
(Parent/Guardian)
Print Name _____ Phone _____
Address_____ City_____State_____ ZIP_____

OR

2) 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:

_____
_____
_____
_____
_____

Non- Consent Signature _____ Date _____
(Volunteer)
Non-Consent Signature_____ Date_____
(Parent/Guardian)
Print Name _____ Phone _____
Address_____ City_____State_____ ZIP_____