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

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:

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________________________ 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 ________________
(Client/Parent or Guardian)
Print Name ______________________________ Phone ________________
Address________________________ City__________ State_____ ZIP__________

<u>OR</u>

2) Non-Consent Plan

I do **<u>not</u>** 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:

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Non- Consent Signature ______________________________ Date ________________
(Volunteer)
Non-Consent Signature______________________________ Date________________
(Client, Parent or Guardian)
Print Name ______________________________ Phone ________________
Address________________________ City__________ State_____ ZIP__________

A COPY OF THE RIDER'S MEDICAL STATEMENT MUST BE ATTACHED TO THIS FORM