



LOVE for Therapeutic Riding

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Tax ID 26-2965095

a faith-based, non-profit program 501 (c)(3)



Authorization of 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 LOVE for TR to Secure and retain medical treatment and transportation if needed. Release client records upon request to the authorized individual or agency involved in the medical emergency treatment.

| | | |
|---------------------------------|-----------|--------------|
| Participant Name: | Phone: | Phone: |
| Address: | City: | State / Zip: |
| If I cannot be reached Contact: | Phone: | Phone: |
| Alternate Emergency Contact: | Phone: | Phone: |
| Physician's Name: | Phone: | |
| Preferred Medical Facility: | | |
| Health Insurance Company: | Policy #: | |

Consent Plan

The 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: (Client, Parent or Guardian): | Date: |
| Please Print Name: | Phone #: |

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:

| | |
|--|----------|
| Consent Signature: (Client, Parent or Guardian): | Date: |
| Please Print Name: | Phone #: |