Authorization for Emergency Medical Treatment

In the event that emergency medical aid/treatment is required due to illness of injury during the process of receiving services or while being on the property of the agency, I authorize **WINDHORSE EQUINE LEARNING** to:

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

Name: _____DOB: _____ Gender Identity: _____

Primary Phone:_____Email:_____

Address: _____City: _____Zip:_____

Physician's name: _____Preferred Medical Facility: _____

Health Insurance: _____Policy #: _____

Medical Conditions: _____

_____

Current Medications: _____

Allergies to Medications: _____

In the event of an emergency, contact:

Name: _____Phone: _____

Name: _____Phone: _____

Consent Plan

This authorization includes x-rays, surgery, hospitalization, medication, and any treatment procedure deemed "life-saving" by physician. This prevision will only be invoked if the person below is unable to be reached.

Date: _____ Consent Signature: _____
Parent or Guardian

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: _____
Parent or Guardian