Dream On Curls Riding Center, INC
153 Kirk Meadow Rd
Springfield, VT 05156
802-885-4126
http://www.dreamoncurls.com/

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT FORM

___ Participant ___ Staff ___Volunteer

Name: _____ DOB: _____ Res Phone: (_____) _____
Address: _____
Physician's Name: _____ Preferred Medical Facility: _____
Health Insurance Company: _____ Policy: _____
Allergies to medication: _____
_____
Current medication: _____
_____
_____
_____

In the event of an emergency contact:
Name: _____ Relation: _____ Phone: (_____) _____
Name: _____ Relation: _____ Phone: (_____) _____
Name: _____ Relation: _____ Phone: (_____) _____

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 DREAM ON CURLS 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.

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(s) above is unable to be reached.

Date: _____ Consent Signature_____
Client, Parent or Legal Guardian
Signed in presence of center staff

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.

- Parent or legal guardian will remain on site at all times during equine assisted activities
- In the event emergency treatment aid is required, I wish the following procedure to take place:

_____
_____
_____

Date: _____ Consent Signature_____
Client, Parent or Legal Guardian
Signed in presence of center staff