

# Seaside Therapeutic Riding

## AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

\_\_\_\_ Participant \_\_\_\_ Staff \_\_\_\_ Volunteer

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_

Physician's Name: \_\_\_\_\_

Preferred Medical Facility: \_\_\_\_\_

Health Insurance Co. \_\_\_\_\_

Policy # \_\_\_\_\_

Allergies to Medications: \_\_\_\_\_

Current Medications:

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Current Health Concerns:

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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 from Seaside Therapeutic Riding Inc., I authorize Seaside

Therapeutic Riding 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.