



HorseSense
 Riding Therapy Program
 A Camillus Foundation Project

Date _____

Rider's Authorization for Emergency Medical Treatment Form

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

In the event I cannot be reached, Contact: _____ Phone: _____

Contact: _____ Phone: _____

Physicians Name: _____

Preferred Medical Facility: _____

Health Insurance Co.: _____ Policy # _____

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.

Date: _____ Consent Signature: _____
 (Client, Parent or Guardian)

Print Name: _____ Phone: _____

Address: _____

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 procedure to take place:

Date: _____ Non-Consent Signature _____
 (Client, Parent or Guardian)

Print Name: _____ Phone: _____

Address: _____

A complete medical history must be attached to this form including all current medications