Ridin' High, Inc
Therapeutic Riding Program
P.O. Box 2282
Morristown, TN 37816
423-585-0331

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

Name: _____ DOB: _____ Phone: _____

Physician's Name:_____ Facility: _____ Phone: _____

Health Insurance Company: _____ Policy# _____

Allergies (Medication/Other) _____

Current Medications: _____

Current Health Concerns: _____

In the event of an emergency:

Primary Contact

Name: _____ Relation: _____ Phone: _____

Secondary Contact

Name: _____ Relation: _____ Phone:_____

In the event emergency medical aid/treatment is required due to illness or injury while being on the property of the agency, I authorize **Ridin' High, Inc**. to:
1. Secure and retain medical treatment and transportation, if needed.
2. Release records upon request to the authorized individual or agency involved in the medical emergency treatment.

CONSENT PLAN I give consent for emergency medical treatment/aid (including x-ray, surgery, hospitalization, medication, and or any treatment procedure deemed "lifesaving" by the physician) in the event of illness or injury while on the property of the agency. **This provision will only be invoked if the person(s) listed cannot be reached.**

Date: _____ Consent Signature: _____

(Client, Parent or Legal Guardian)

NON-CONSENT PLAN I do NOT give consent for emergency medical treatment/aid in the event of illness or injury while 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: _____

(Client, Parent or Legal Guardian)