Authorization for Emergency Medical Treatment

Name: _____DOB: _____Phone: _____

Address: _____

Physician: _____Preferred Medical Facility: _____

Health Insurance Co: _____Policy: _____

Allergies: _____

Current Medications: _____

Emergency Contact: _____Phone: _____

Emergency Contact: _____Phone: _____

Consent Plan: In the event emergency medical aid/treatment is required due to illness or injury while on the property of Meadows Town Ranch/Equinox Horse Foundation, I authorize **Equinox Horse Foundation** 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 treatment.

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.

Consent signature: _____Date: _____
Client, Parent or Legal Guardian

Print Name: _____

Non-Consent Plan: I do not give my consent for emergency medical treatment/aid in the case of illness or injury while on the property of Meadows Town Ranch/Equinox Horse Foundation.

1. Parent or legal guardian will remain on site at all times during activities with Equinox Horse Foundation.
2. In the event emergency treatment/aid is required, I wish the following procedure to take place:

   _____

   _____

Non-Consent Signature: _____Date: _____