# AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT
# **RIDER**

In the event emergency medical aid treatment is required due to illness or injury during the course of riding with the **EQUI-KIDS Therapeutic Riding Program**, or while being on said premises of the organization, I hereby authorize **EQUI-KIDS Therapeutic Riding Program** and/or its representatives to:

1. Obtain medical treatment and/or transportation if needed; and
2. Release client records upon request to the authorized agency or its representative involved in the medical emergency treatment

Participant Name:_____Telephone:_____
Address:_____City/State/ZIP:_____

**In the event that either I or my child is unconscious, please contact:**

Name:_____ Telephone:_____
Relationship:_____
Physician's Name:_____ Telephone:_____
Medical Facility:_____ Telephone:_____
Health Insurance Company:_____ Telephone:_____

In an effort to provide the best care possible, please indicate below:

*I am/my child is* allergic to the following medications: _____

_____

*I have/my child has* the following ongoing medical conditions: (i.e.: Diabetes, Seizures, etc):

_____

Date:_____ _____

Participant/Parent/Guardian/Caretaker

# **NON-CONSENT FOR MEDICAL TREATMENT**

I/We **DO NOT** give consent for emergency medical treatment for myself/my child in the case of illness or injury during the course of participating in the lesson program or while on the premises of the **EQUI-KIDS Therapeutic Riding Program.**

In the event emergency treatment/aid is required, I wish the following procedure to take place:

_____

Date:_____ _____

Participant/Parent/Guardian/Caretaker

Printed Name:_____

Address:_____

City, State, Zip:_____

Phone:_____

**PREMIER ACCREDITED CENTER OF PATH, INTL.**

***Revised: 5/2011***