



Good Hope Equestrian Training Center, Inc
 22155 SW 147 Avenue
 Miami, FL 33170
 (305) 258-2838

Authorization for Emergency Medical Treatment Form

Participant Staff Volunteer

Name: _____ DOB: _____ Phone #: _____
 Address: _____
 Physician's Name: _____ Preferred Medical Facility: _____
 Health Insurance Company: _____ Policy #: _____
 Allergies to medications: _____
 Current Medications: _____

In the event of an emergency, contact:

Name: _____ Relationship: _____ Phone: _____
 Name: _____ Relationship: _____ Phone: _____
 Name: _____ Relationship: _____ Phone: _____

In the event emergency medical aid/treatment is required due to illness or injury during the process of receiving services, or while being on the property of the agency, I authorize **Good Hope Equestrian Training Center, 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.

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(s) above is unable to be reached.

Date: _____ Consent Signature: _____
 Client, Parent, or Legal Guardian
Signed in the presence of center staff

Non-Consent Plan

I do not give 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.

- Parent of legal guardian will remain on site at all times during equine assisted activities
- In the event emergency treatment/aid is required, I wish the following procedure to take place:

Date: _____ Consent Signature: _____
 Client, Parent or Legal Guardian
Signed in the presence of center staff