SpringHaven 2024 Beginner Riding Camp
Authorization for Emergency Medical Treatment Form

Name: _____ DOB: _____

Phone: (H)_____(W)_____(C)_____

Address: _____

Physician's Name: _____ Medical Facility: _____

Health Insurance Company: _____ Policy #: _____

Allergies to Medications:

_____

Current Medications:

_____

Allergies to Food:

_____

In the event of an emergency, contact: (at least one)

Name: _____ Relation: _____ Phone: _____

Name: _____ Relation: _____ Phone: _____

Name: _____ Relation: _____ 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 SpringHaven, 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 will only be invoked if the person(s) above is unable to be reached.

Consent Signature: _____ Date:_____
Legal Guardian (if participant is a minor)

Consent Signature: _____ Date: _____
Witness

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 procedures to take place:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Non-Consent Signature: _____ Date: _____
Legal Guardian (if participant is a minor)

Non-Consent Signature: _____ Date: _____
Witness