SpringHaven Equine Homeschool Program
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:

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

Non-Consent Signature: ____ Date: ____________
Witness