Albany Therapeutic Riding Center, Inc.

182 Martin Road Extension, Voorheesville, NY 12186

518-765-2764

albanytherapeuticridingcenter@gmail.com

Emergency Medical Treatment Authorization Form

Name:_____ DOB:_____ Phone:_____

Address:

_____

_____

_____

Physician Information:

Name: _____

Clinic Address:

_____

_____

_____

Phone: _____

Health Insurance Company:_____ Policy #:_____

Allergies to medication: _____

Current medications and dosage:_____

_____

Emergency Contact #1:

Name: _____

Relation: _____

Phone: _____

Emergency Contact #2:

Name: _____

Relation: _____

Phone: _____

Preferred Medical Facility: _____

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 Albany Therapeutic Riding Center, Inc., I authorize Albany Therapeutic Riding Center, Inc. to:

1. Secure and retain medical treatment and transportation if needed.
2. Release my medical, lesson 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 none of the persons listed above are unable to be reached.

Participant Signature: _____ Date: _____

Name of Signatory (please print): _____

If Participant is age seventeen or younger, or an incompetent adult, there must be consent by a Parent or Guardian as follows: I hereby certify that I am the Parent or Guardian of the Participant named above and am signing below as an individual and in my capacity as the Parent or Guardian of the Participant and hereby give my consent without reservation to the foregoing on behalf of the Participant.

Signature: _____ Date: _____

Parent or Legal Guardian Name of Signature (please print):

_____

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:

_____

_____

_____

Participant Signature: _____ Date: _____

Name of Signatory (please print): _____

If Participant is age seventeen or younger, or an incompetent adult, there must be consent by a Parent or Guardian as follows: I hereby certify that I am the Parent or Guardian of the Participant named above and am signing below as an individual and in my capacity as the Parent or Guardian of the Participant and hereby give my consent without reservation to the foregoing on behalf of the Participant.

Signature: _____ Date: _____

Parent or Legal Guardian Name of Signature (please print):

_____