CAROLINA HORSEMANSHIP, INC

Authorization for Emergency Medical Treatment

Name:_______________________________________ DOB: ___/___/___ Phone:_______________________

Address:_____________________________________ City:____________________State:_____ Zip:_________

Physicians's Name:____________________________Medical Facility:__________________________________

Health Insurance Company:____

Allergies to Medications:____

Current Medications:____

In the event of an emergency, contact:

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, I authorize Carolina Horsemanship, 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-rays, surgery, hospitalization, medication, and any treatment procedure deemed "life saving" by the physician. This provision will only be invoked if the person(s) above cannot be reached.

Date:___________ Consent Signature:____
Client, Parent, or Legal Guardian

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

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Date:_____________ Consent Signature:____
Client, Parent, or Legal Guardian