# 2007 EXCEPTIONAL EQUESTRIANS UNLIMITED, INC.,

## AUTHORIZATION for EMERGENCY MEDICAL TREATMENT

_____Participant _____ Volunteer _____ Instructor

Name_____Date of Birth_____Phone_____

Address_____Zip_____

Physician's Name_____Preferred Medical Facility_____

Health Insurance Company_____ Policy #_____

Allergies to medications_____

Current medications_____

In the event of an emergency contact:

Name:_____Relation:_____Phone:_____

Name:_____Relation:_____Phone:_____

Nane:_____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 *Exceptional Equestrians Unlimited, Inc.:*

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 presence of operating center staff

**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.

Parent or 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 presence of operating center (EEU) instructor

Send to: Exceptional Equestrians Unlimited Inc.
5307 B East 61st Avenue
Hobart, IN 46342
eeu1.org 219/945-0726