Whispers of Hope
Horse Farm

Rider's Authorization for Emergency Medical Treatment

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 Whispers of Hope Horse Farm to secure and retain medical treatment and transportation if needed.

Release any records upon request to the authorized individual or agency involved in the medical emergency treatment.

Rider Name: ____ Date of Birth: ______________________

Parent/Guardian: ____

Home Phone: ___________________________________ Work Phone: ______________________________

Cell Phone: ___________________________________ Email: ___________________________________

Address: ___________________________________ City: ______________________________________

State: _______ Zip Code: _______________

Emergency contact: #1: ___________________________________ Phone: _______________________

#2: ___________________________________ Phone: _______________________

Physician's Name: ____

Preferred Medical Facility: ____

Health Insurance Co.: ___________________________________ Policy # ______________________________

Rider's Disability, if applicable: ____

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Describe any medical condition requiring special precautions or treatment and any medications with dosage:

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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 below is unable to be reached.
Date: ________________________________ Consent signature: ____
Client, Parent or Guardian

Contact Name: ___________________________________ Phone: _____________________________________

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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Date: ___________________________Non-Consent signature: ____
Client, Parent or Guardian

Print Name: ___________________________________