



SPRINGPOINT FARM RIDING PROGRAM

144 Bowie Hill Road, Durham, Maine 04222

207-926-5789

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

In the event 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 Springpoint Farm Therapeutic Riding Program to:

1. Secure and retain medical treatment and transportation if needed.
2. Release rider's records upon request to the authorized individual or agency involved in the medical emergency treatment

Rider's Name: _____ Phone: _____

Address: _____

In Case of Emergency Please Contact: Name: _____ Phone: _____

Name: _____ Phone: _____

Physician's Name: _____

Preferred Medical Faculty: _____

Health Insurance Co.: _____ Policy #: _____

(YOU MUST SIGN ONLY ONE OF THE PLANS BELOW)

Consent Plan: This authorization includes x-ray, surgery, hospitalizations, medication and any treatment deemed "life-saving" by the physician. This provision will only be invoked if the person listed herewith is unable to be reached.

Date: _____ Consent Signature: _____

(Rider, Parent or Guardian)

Print Name: _____

Address: _____

*****OR*****

Non-Consent Plan:

I do not give my consent for emergency medical aid/treatment in the case of illness or injury during the process of volunteer participation or while being on the property of the agency. In the event emergency aid/treatment is required I wish the following procedures to take place:

Date _____ Non-Consent Signature: _____

If your child has special needs or requires care at a specific facility please list the need or facility below:

Drug Allergies or Other Known Allergies:

Current Conditions or Medications:

All client information contained in this release is strictly confidential and for use only by the attending professional.

