



A H O R S E C O N N E C T I O N

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

Participant's Name: _____ Date of Birth: _____ Age: _____

Address: _____

Physician's Name: _____ Medical Facility: _____

Health Insurance Co.: _____ Policy No.: _____

Allergies to medications? _____

Current medications: _____

In the event of an emergency, contact:

Name: _____ Relation: _____ Phone: _____

Name: _____ Relation: _____ Phone: _____

Name: _____ 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, and the above cannot be reach, I authorize

Nancy King, OTR/L to:

- 1) Secure and retain medical treatment and transportation if needed.
- 2) Release participants 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 above is unable to be reached.

Date: _____

Consent Signature : _____ (Client, Parent or Legal Guardian)

MUST BE SIGNED IN THE PRESENCE OF OPERATING CENTER STAFF