Appalachian Therapeutic Riding Center
Authorization for Emergency Medical Treatment Form

☐ Participant ☐ Staff ☐ Volunteer

Name _____

Address _____
Street / PO Box *City* *State* *Zip*

Telephone _____ DOB _____

Physician's Name _____ Medical Facility _____

Health Insurance Company _____ Policy # _____

Allergies to Medications _____

Current Medications _____

In the event of an emergency, contact:

Name _____ Relation _____ Phone _____

Name _____ Relation _____ Phone _____

Name _____ Relation _____ Phone _____

In the event of emergency medical aid/treatment is required to due illness or injury during the process of receiving services, or while being on the property of the agency, I authorize Appalachian Therapeutic Riding Center to:

1. Secure and maintain medical treatment and transportation if needed.
2. Release participant 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.

Consent Signature _____ Date _____
Participant, parent or legal guardian

Witness _____ Date _____

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:

_____

_____

Consent Signature _____ Date _____
Participant, parent or legal guardian

Witness _____ Date _____

Warning: Under North Carolina Law, an equine activity sponsor or equine professional is not liable for an injury to or the death of a participant in equine activities resulting exclusively from the inherent risks of equine activities. Chapter 99E of the North Carolina Statues.

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