Authorization for Emergency Medical Treatment Form

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 premises operated by Rising Tide Therapeutic Equestrian Center, Inc., I authorize Rising Tide Therapeutic Equestrian Center Inc. to:

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.

Client's Name:_________________________________Phone____________________
Family Address:____

In the event I cannot be reached, Contact:___________________Phone:_____________
Contact:___________________Phone:_____________
Physician's Name:____________________________________Phone:______________

Health Insurance Co:_____________________________Policy #___________________

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)

PRINT Name:_____________________________________Phone:_________________
Address:____

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:____
____
____

Date:___________Non-Consent Signature:_____________________________________
(Client, Parent or Guardian)

PRINT Name:___________________________________Phone:___________________
Address:____

RISING TIDE THERAPEUTIC EQUESTRIAN CENTER, INC

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