Charleston Area Therapeutic Riding, Inc.
P.O. Box 146 • Johns Island, SC 29457-0146 • (843) 559-6040 • Fax (843) 559-0176

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AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

Student:_____ Date of Birth: _____
Address: _____
City: _____State: _____ Zip Code: _____
Home Phone: _____ Work Phone: _____ Cell: _____
Health Insurance Co: _____Policy #: _____
Allergies to Medications: _____
Current Medications: _____

In the event of an emergency, contact:
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, I authorize Charleston Area Therapeutic Riding, 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.

PLEASE SIGN ONLY ONE CONSENT

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.

_____ _____
Date Participant, Parent or Legal Guardian

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 procedure to take place:

_____

_____

_____

_____ _____
Date Participant, Parent or Legal Guardian