DREAM RIDERS

Volunteer Authorization for Emergency Medical Treatment Form

Name_____ DOB_____
Home Phone_____ Cell Phone _____
Address_____
Email:_____
Physician's Name:_____ Preferred 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: _____

Consent Plan
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 DREAM RIDERS 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.

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: _____ Consent Signature: _____
Volunteer, Parent or Legal Guardian if under 18

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.

O In the event emergency treatment/aid is required, I wish the following procedure to take place:
_____
_____
_____

Date: _____ Non-Consent Signature: _____
Volunteer, Parent or Legal Guardian if under 18

PREMIER ACCREDITED CENTER
PATH INTERNATIONAL
Professional Association of Therapeutic Horsemanship International