AUTHORIZATION FOR EMERGENCY MEDICAL

Participant's Name: ____

(Please Print)

In case of Emergency, please contact ________________________________ Phone(s) ____________________

Physician's Name: ____ Phone: _____________________

City: ____

Please indicate any allergies____

Please indicate any medical issues that may effect your/your child's participation at Cross Creek Meadows: _____________

Date of last Tetanus Shot: __________________

CONSENT PLAN: I give consent for emergency medical treatment/aid (including x-ray, surgery, hospitalization, medication, and any treatment procedure deemed "life saving" by the physicians). In the event emergency medical aid/treatment is required due to illness or injury during the process of receiving services, any participation on my part at Cross Creek Meadows, or while being on the property of Cross Creek Meadows, I authorize Cross Creek Meadows Therapeutic Riding Center to:

1. Secure and retain medical treatment and transportation, if needed.
2. Release records upon request to the authorized individual or agency involved in the medical emergency treatment.

Participant's Consent Signature _______________________________ Date: ______________________

Signature of Parent/Guardian ____

(If participant is under 18 years of age)

NON-CONSENT PLAN: I do not give consent for emergency medical treatment/aid in the event of illness or injury during the process of receiving services, any participation on my part at Cross Creek Meadows, or while being on the property of Cross Creek Meadows Therapeutic Riding Center. In the event emergency treatment/aid is required, I wish the following procedures to take place:

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Participant's Signature _____________________________________ Date: ____________________

Signature of Parent/Guardian ____

(If participant is under 18 years of age)