

SunDance Riding Therapy, Inc.
Authorization for Emergency Medical Treatment Form
(This form is valid for three years)



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 SunDance Riding Therapy, Inc. to secure and retain medical treatment and transportation if needed.

Name _____ Telephone _____

Address, City, State and Zip Code _____

1st Emergency Contact _____ Telephone _____

2nd Emergency Contact _____ Telephone _____

Physician Name _____ Hospital/Clinic _____

Health Insurance Company _____

Health Insurance Policy Number _____

Consent Plan

This authorization includes X-rays, surgery, hospitalization, medication, and any treatment procedures deemed “life saving” by the physician. This provision will only be invoked if the person below is unable to be reached.

Signature _____ Date _____

Print Name _____ Telephone _____

Address, City, State & Zip _____

(Continued)

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: _____

Signature _____

Date _____

Print Name _____

Telephone _____

Address, City, State & Zip _____