Kelli Gerrior, Instructor

Date filled out: _____

ROAMING PONY FARM LLC

EMERGENCY MEDICAL TREATMENT

Student Name: _____ DOB: _____

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: _____

PLEASE SIGN ONE OF THE TWO FOLLOWING BOXES

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 Roaming Pony Farm LLC 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.
Consent Signature: _____ Date: _____
Client, Parent or Legal Guardian (please indicate which of these is relevant)

This document to be counter-signed by center staff.
Staff Signature: _____ Date: _____

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.

[ ] Parent of legal guardian will remain on site at all times during equine-assisted activities.
[ ] In the event emergency treatment/aid is required, I wish the following procedures to take place:

_____

_____