SOUTHERN VERMONT
Therapeutic Riding Center

3 Cross Country Circle, Wilmington, VT 05363 www.sovtrc.org (802) 221-4409

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

_____Participant _____Staff _____Volunteer

Name:_____ DOB:_____ Phone:_____
Physician's Name:_____ Preferred Medical Facility:_____
Health Insurance Co:_____ Policy #:_____
Current Allergies, Medications, and Health Concerns: _____
_____

In the event of an emergency:
Emergency Contact 1:_____ Relation:_____
Home Ph:_____ Work Ph: _____ Cell Ph:_____
Emergency Contact 2:_____ Relation:_____
Home Ph:_____ Work Ph: _____ Cell Ph:_____

In the event that 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 the Southern Vermont Therapeutic Riding Center 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.

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) listed cannot be reached.**

Date:_____ Consent Signature:_____
Client, Parent, or Legal Guardian

NON-CONSENT PLAN

I do not give 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 (please give details below): _____
_____

Date:_____ Consent Signature:_____
Client, Parent, or Legal Guardian