Authorization for Emergency Medical Treatment

Name:_____ DOB:_____ Phone:_____

Address:_____

Physician's Name:_____ Preferred Medical Facility:_____

Health Insurance Company:_____ Policy #:_____

Allergies to Medications:_____

Current Medications:_____

In the event of an emergency:

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 Follow Your Dreams 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.

Date:_____ Consent Signature:_____

Client, Parent or Legal Guardian

Non-Consent Plan

I do not give my consent for emergency medical aid/treatment in the case of illness or injury during the process of receiving services or while being on the property of the agency.

Parent or legal guardian will remain on site at all times during equine activities.
In the event emergency treatment/aid is required, I wish the following procedure to take place:

_____

_____

_____

Date:_____ Non-Consent Signature:_____

Client, Parent or Legal Guardian