Lichen Oaks Adaptive Riding Center

114 Quail Hollow Road, CA 95018
(831) 335-2347
lichenoaksarc.org
info@loarc.net

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT FORM

____ Participant ____ Staff ____ Volunteer

Name: ______________________ DOB: __________ Phone: ______________________

Address: ____

Physician's name: ____

Preferred Medical Facility: ____

Health Insurance Co: ______________________ Policy #: ______________________

Allergies to any medications: ____

Current medications (prescription and over-the-counter): ______________________

In the event of an emergency, contact:

Name: ____________________ Relation: ________________ Phone: ______________

Name: ____________________ Relation: ________________ Phone: ______________

Name: ____________________ Relation: ________________ Phone: ______________

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 **Lichen Oaks Adaptive Riding Center** to: (1) Secure and retain medical treatment and transportation if needed, and (2) Release client records upon request to the authorized individual or agency involved in 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) above cannot be reached.

Date: ______________ Consent Signature:____
Client, parent or legal guardian

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

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Date: ______________ Signature: ____
Client, parent or legal guardian