simple changes
THERAPEUTIC RIDING CENTER

Authorization for Emergency Medical Treatment

☐ Participant ☐ Staff

Mail To:
Simple Changes
PO Box 991
Lorton, VA 22199

Name: _____ DOB: _____ Phone: _____

Address: _____

Health Insurance Company: _____ Policy #:_____

Physician's Name: _____ Physician's Phone:_____

Allergies to medications: _____

Current medications: _____

In the event of an emergency, contact:

1. Name: _____ Relation: _____ Phone: _____

2. Name: _____ Relation: _____ Phone: _____

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 Simple Changes, Inc. 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) above is unable to be reached.

Signature: _____ **Date**: _____
Participant (if over 18), Parent or Legal Guardian

Subsequent Year Initials: _____ Date: _____ Subsequent Year Initials: _____ Date: _____
Participant (if over 18), Parent or Legal Guardian Participant (if over 18), Parent or Legal Guardian

OR ☐ 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 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 procedure to take place:

_____

_____

Signature: _____ **Date**: _____
Participant (if over 18), Parent or Legal Guardian