

**Hoofbeats Therapeutic Riding Center, Inc.**

At the Virginia Horse Center  
P.O. Box 979, Lexington, VA 24450  
Phone: (540) 464-3337 E-mail: hoofbeats@rockbridge.net  
Website: [www.hoof-beats.com](http://www.hoof-beats.com)

North American Riding for the Handicapped Association, Inc.  
A Premier Accredited Member Operating Center

**AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT FORM**

**Check one: \_\_\_Participant \_\_\_Volunteer \_\_\_Staff**

Name (of Participant, Volunteer or Staff Member): \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Preferred Medical Facility \_\_\_\_\_

Physician's Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Health Insurance Co.: \_\_\_\_\_ Policy # \_\_\_\_\_

**Emergency Contacts:**

Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Phone: \_\_\_\_\_

Allergies to Medications: \_\_\_\_\_

Current Medications: \_\_\_\_\_

In the event emergency medical aid/treatment is required due to illness or injury during the process of receiving services, volunteering, or while being on the property of the agency, I hereby authorize **Hoofbeats Therapeutic Riding Center, Inc.** to:

1. Secure and retain medical treatment and transportation if needed.
2. Release client or volunteer records upon request to the authorized individual or agency involved in the emergency medical treatment.

**CONSENT PLAN (Parents/legal guardians must sign for children under 18 or for wards of the court)**

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 below is unable to be reached.

Date: \_\_\_\_\_ Consent Signature: \_\_\_\_\_

Print Name: \_\_\_\_\_

Phone: \_\_\_\_\_ Address: \_\_\_\_\_

**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, volunteering, or while being on the property of the agency. In the event emergency aid/treatment is required, I wish the following procedures to take place (If you choose this plan, you must fill in some specifics for the aid which you will/will not allow)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Date: \_\_\_\_\_ Non-Consent Signature: \_\_\_\_\_

Print Name: \_\_\_\_\_

Phone: \_\_\_\_\_ Address: \_\_\_\_\_