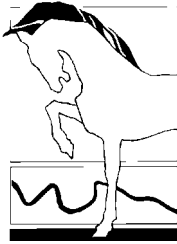


AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT FORM

To be completed by the participant, parent or legal guardian



**River Cities
Therapeutic Riding
Center, Inc.**
Administrative Offices and Facilities:
C/O Golden-Aire Farm
RR 3 Box 397
Milton, WV 25541
(304) 743-5267
<http://rctrc.org>

GENERAL INFORMATION		
Last Name: _____ First Name: _____ Name: <i>(Last, First, M.I.)</i>	<input type="checkbox"/> M <input type="checkbox"/> F	DOB: ____/____/____
Are you a: <input type="checkbox"/> Client <input type="checkbox"/> Staff <input type="checkbox"/> Volunteer		Age: _____
Address:		
City, State and Zip Code:		
E-mail Address:	Phone:	Alternative #:
Physician's Name:	Preferred Medical Facility:	
Health Insurance Company:	Policy Number:	
Parent/Legal Guardian:		
Address: (if different from above)		Phone:
In the event of an emergency, contact:		
Name:		Phone:
Name:		Phone:
PERSONAL HEALTH HISTORY		
Allergies to Medications:		
Medications: (Please include prescription, over-the-counter: name, dose and frequency)		
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 RCTRC, Inc., I authorize River Cities Therapeutic Riding Center, Inc. to:		
<input type="checkbox"/> Secure and retain treatment and transportation if needed.		
<input type="checkbox"/> Release client records upon request to authorized individual or agency involved in the medical emergency treatment.		
CONSENT PLAN		
<input type="checkbox"/> This authorization includes x-rays, surgery, hospitalization, medication and any treatment procedure deemed "life saving" by the physician. This provision will only be invoked if the person(s) above in unable to be reached.		
Signature: _____		
MUST BE SIGNED IN THE PRESENCE OF RCTRC, INC. STAFF		
Client, Parent or Legal Guardian Signature: _____		
Witness RCTRC, INC. STAFF Signature: _____		
NON-CONSENT PLAN		
I do not give my consent of emergency medical treatment/aid in the case of illness or injury during the process of receiving services or while being on the property of RCTRC, Inc.		
<input type="checkbox"/> Parent or legal guardian will remain on site at all times during therapy session.		
<input type="checkbox"/> In the event emergency treatment/aid is required, I wish the following procedures to take place: x-rays, CPR, Surgery		
Signature: _____		
MUST BE SIGNED IN THE PRESENCE OF RCTRC, INC. STAFF		
Client, Parent or Legal Guardian Signature: _____		Date: _____
Witness RCTRC, INC. STAFF Signature: _____		Date: _____