Authorization for Emergency Medical Treatment

Rider's name______________________________ DOB____________ Age________________ Grade______ School____________________________

Address____________________________ City__________ State_________ Zip_________ Previous riding experience? ______None ______Beginner_____Advanced ________Therapeutic support

Home Phone______________________________ Mother's Name/ Cell________________________________ Father's Name/ Cell ______________________

Primary Physician ____________________________ Phone____________________________ Medical clearance______________________________

Preferred Medical Facility ______________________________ Health Insurance______________________ Policy #______________________________

Current Medications__________________ Allergies____________ Medical Contraindications____

Consent Procedures

In the event of an emergency medical need or treatment is required due to injury or illness while receiving services or if on the premises of LeCheval Stable, I authorize LeCheval to:

_____Contact medical treatment and transportation as needed _____Release rider records as requested to authorized persons needed for medical treatment This includes hospitalization, x-ray, medication, surgery, or any medical treatment procedure deemed "life saving" by the physician or emergency team. The provision will only be used if the person(s) above are unable to be reached.

Printed name ______________________ Phone #______________ Consent Signature________________________________ Date________________

Non-Consent Procedures

I do not give my consent for emergency medical treatment in the case of illness or injury while receiving services or while on the premises of LeCheval Stable.

___Parent, legal guardian or caretaker **will remain on the premises at all times during equine related activities.** ___I wish alternate procedures to occur in the event that medical emergenc treatment isneeded (describe)

____

Printed name__________________________ Phone # ______________ Non-Consent signature________________________ Date__________________