Participant's Authorization for Emergency Medical Treatment

Participant Name:_____DOB_____Phone_____
Address:_____

Physician Name:_____
Health Insurance Company:_____Policy Number:_____

Allergies:_____

Medical Conditions/Diagnosis:_____

Current Medications:_____

In the EVENT OF EMERGENCY contact:_____

Name:_____

Name:_____

In the event emergency medical treatment/aid is required due to illness or injury during the process of receiving services, or while being on the property of Unicorn Therapeutic Riding at 171 Marshalls Corner Woodsville Rd, Pennington NJ , I authorize Unicorn to:

1) Secure and retain medical treatment if needed.
2) Release pertinent 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 emergency contact(S)

Above is(are) unable to be reached.

Consent Signature:_____Date_____

Witness:_____Date_____

Non-Consent Plan

I do not give my consent for emergency medical treatment in the case of illness or injury while I/my child participates in Unicorn Therapeutic Horseback Riding. In the event emergency treatment is required, I wish the following procedure to be
followed:_____

Print Name_____

Non-Consent
Signature_____Date_____