Participant's Authorization for Emergency Medical Treatment
Participant Name:DOBPhone Address:
Physician Name: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:
 Secure and retain medical treatment if needed. 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 SignatureDate