Equi★Star, Inc.

Horseback Riding Center

PO Box 25, 2199 Fuller Road, Newfane NY 14108 716-778-8249

RIDER AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

In the event that emergency medical aid/treatment is required due to illness or injury during the process of receiving services, or while being on the property of the agency, I authorize Equi★Star, Inc. to:

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

Rider's Name	DOB	Age *
Address, City, Zip	Home Phone	
Email address:	Cell Phone	
In the event that I can not be reached, contact:	Contact #1 Phone	
In the event that I can not be reached and a second contact is needed:	Contact #2 Phone	
Physicians Name	Physician's Phone	
Preferred Medical Facility		
Health Insurance Co.	Policy #	

**** minimum age of 3 ½***
**** maximum weight of 200 lbs***

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 person below is unable to be reached.

_____ _____

Date Consent Signature of Client, Parent or Guardian Signature

_____ _____

(Print Name) (Print Phone)

Address_____

City_____ Zip _____

over →

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 or while being on the property of the agency. In the event emergency treatment/aid is required, I wish the following procedures to take place:

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_____

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_____

_____ _____

Date Non-Consent Signature of Client, Parent or Guardian Signature

_____ _____

(Print Name) (Print Phone)

Address_____

City_____ Zip _____

A COPY OF THE COMPLETED MEDICAL HISTORY SHOULD BE ATTACHED TO THIS FORM