Horse Helpers of the High Country

Authorization of Emergency Medical Treatment Form

A 501(c)3 Non Profit Horse Rescue Organization
1199 Odes Wilson Rd.
Zionville, NC 28698 / 828-297-1833
www.HorseHelpersNC.org / HorseHelpersNC@gmail.com

This form must be completed and submitted for EVERY participant at Horse Helpers, Inc. (HHHC) before engaging in ANY horse-related activity. It is the participant's responsibility to ensure that all the information is complete and accurate and to notify HHHC in the event of any changes. This document waives important legal rights. Read it carefully before signing.

In the event emergency medical aid/treatment is required due to illness or injury while being on the property of Horse Helpers, Inc (HHHC), I authorize HHHC to secure and retain medical treatment and transportation if needed. Release client records upon request to the authorized individual or agency involved in the medical emergency treatment.

Participant Name: _____ *Birth Date:* _____

Home Phone: _____ *Cell Phone:* _____

Address: _____

City: State / Zip: _____

If I cannot be reached Contact/Relationship: _____

Home or Work Phone: _____ *Cell Phone:* _____

Alternate Emergency Contact/Relationship: _____

Home or Work Phone: _____ *Cell Phone:* _____

Physician's Name: _____

Phone: _____

Health Insurance Company: _____

Policy #: _____ *Phone #:* _____

List all special medical conditions, medications or allergies that staff or emergency personnel should be aware of:

_____

Optional Authorization for Treatment

The undersigned participant, and parents or legal guardian of a minor participant, authorizes members of HHHC as agent(s), to consent to any x-ray, anesthetic, medical or surgical diagnosis or treatment and hospital care deemed advisable and rendered by any licensed physician, licensed emergency medical technician or surgeon, whether on HHHC property, in a remote location, in an office or in a licensed hospital. This authorization is given in advance of any required care to empower the agent(s) to give consent for such treatment as the health care giver may deem advisable. This Authorization shall remain effective indefinitely unless revoked in writing.

Signature: _____ *Date:* _____

Participant / Volunteer / Legal Guardian Signature (please list for whom you are signing)