DREAM a DREAM THERAPEUTIC HORSEMANSHIP
23650 Round Mountain Circle, Leander, TX 78641
(512) 260-5957 | info@dadth.org

AUTHORIZATION for EMERGENCY MEDICAL TREATMENT FORM

Name: _____ DOB: _____
Phone: _____
Address: _____
Physician's Name: _____
Preferred Medical Facility: _____
Health Insurance Company:_____ Policy Number: _____
Allergies to medications: _____
Current medications: _____
In the event of an emergency, contact:
Name: _____ Relation: _____ Phone: _____
Name: _____ Relation: _____ Phone: _____

****

CONSENT PLAN

In the event emergency medical aid/treatment is required due to illness or injury during the process of receiving services, or while being on the property of D.a.D.T.H., I authorize D.a.D.T.H. 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.

This authorization includes x-ray, surgery, hospitalization, education, and any treatment procedure deemed "lifesaving" by the physician. This provision will only be invoked if the person(s) above is unable to be reached.

Date: _____ Consent Signature: _____
Signature of legally authorized person, client, parent or guardian

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.

1. Parent or legal guardian will remain on site at all times during equine assisted activities.
2. In the event emergency treatment/aid is required, I wish the following procedure to take place:

_____

_____

_____

Date: _____ Non-Consent Signature: _____
Signature of legally authorized person, client, parent or guardian