



# Hackney's Hope

Hackney's Hope Riding Program  
~Life has its spirit and majestic moments~

## Authorization For Emergency Medical Treatment

\_\_\_ Participant    \_\_\_ Staff    \_\_\_ Volunteer

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Physician's name: \_\_\_\_\_

Health Insurance Co:  
\_\_\_\_\_

Allergies (medications/other): \_\_\_\_\_

Current Medications: \_\_\_\_\_

Current Health Concerns: \_\_\_\_\_

Preferred Medical Facility: \_\_\_\_\_

In the event of an emergency:  
Emergency contact: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Emergency contact 2: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

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 Hackney's Hope Riding Program 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.

### 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(S) LISTED CANNOT BE REACHED.**

Date: \_\_\_\_\_ Consent Signature: \_\_\_\_\_

### NON-Consent plan

I do not give 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 (please give details below):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Date: \_\_\_\_\_ Non-Consent Signature: \_\_\_\_\_