

# THE RIDING CENTRE

1117 East Hyde Road Yellow Springs, Ohio 45387

## Rider's Authorization for Emergency Medical Treatment Form

(Please Print)

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 the agency, I authorize The Riding Centre 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.

Client: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

In the event I cannot be reached, contact: \_\_\_\_\_ Phone: \_\_\_\_\_

contact: \_\_\_\_\_ Phone: \_\_\_\_\_

Physician's Name: \_\_\_\_\_

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

Health Insurance Co.: \_\_\_\_\_ Policy #: \_\_\_\_\_

### Consent Plan

This authorization includes x-ray, surgery, hospitalization, medication and any treatment deemed "life saving" by the physician. This provision will only be invoked if the person below is unable to be reached.

Date: \_\_\_\_\_ Consent Signature: \_\_\_\_\_  
(Client/Parent/Guardian)

Print Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

### 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:

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

Date: \_\_\_\_\_ Non-Consent Signature: \_\_\_\_\_  
(Client/Parent/Guardian)

Print Name: \_\_\_\_\_ Phone: \_\_\_\_\_

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

Under Ohio Law, an Equine Activity Sponsor or Equine Professional is not liable for an injury to or the death of a participant in equine activities resulting from inherent risks of equine activities. (Ohio Revised Code 2305.321)