VOLUNTEER EMERGENCY CONTACT & MEDICAL TREATMENT FORM

VOLUNTEER NAME

EMERGENCY CONTACTS

PRIMARY EMERGENCY CONTACT

PHONE NUMBER

ALTERNATE EMERGENCY CONTACT

PHONE NUMBER

PHYSICIAN NAME

PREFERRED MEDICAL FACILITY

HEALTH INSURANCE COMPANY

POLICY NUMBER

CURRENT MEDICATIONS

MEDICATION ALLERGIES

CONSENT PLAN

In the event emergency medical treatment/aid is required due to illness or injury during the process of receiving services or while being on the property of the agency, I authorize Hold Your Horses, LLC 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 medication and any treatment procedure deemed "life saving" by the physician.

This provision will only be invoked if the "Emergency Contact(s)" listed on this form is/are unable to be reached.

VOLUNTEER CONSENT SIGNATURE

DATE

PARENT/GUARDIAN SIGNATURE
(If Volunteer is under 18 Years of Age)

DATE