Cochise Area Network of Therapeutic Equestrian Resources, C.A.NT.E.R.

PO Box 1316, Sierra Vista, AZ 85636

Authorization for Emergency Medical Treatment

☐ Client ☐ Staff ☐ Volunteer

Name ______ D.O.B. ______ Phone Number ______

Address ______ City ______ State ______ ZIP ______

Physician's Name ______ Preferred Medical Facility ______

Health Insurance Company ______ Policy # ______

Current Medications ______ Allergies to medications ______

Emergency Contact 1 ______ Relationship ______ Phone Number ______

Emergency Contact 2 ______ Relationship ______ Phone Number ______

Emergency Contact 3 ______ Relationship ______ Phone Number ______

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 the agency, I authorize the Cochise Area Network of Therapeutic Equestrian Resources (CANTER) to

1. secure and retain medical treatment and transportation if needed, and
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 person(s) above is unable to be reached.

Consent Signature ______ Date ______

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 Cochise Area Network of Therapeutic Equestrian Resources (CANTER).

☐ Parent or legal guardian will remain on site at all times during equine-assisted activities.

☐ In the event emergency treatment/aid is required, I wish the following procedure to take place:

Non-consent Signature ______ Date ______