

## Authorization for Emergency Medical Treatment Form

**Participant**     
  **Staff**     
  **Volunteer**

In the event medical aid/treatment is required due to illness or injury during the process of participating, volunteering, or while being on the property of Willow Creek Ranch, Inc., I authorize a representative of WCR to secure and retain medical treatment and transportation if needed. Upon request, records will be released to the authorized individual or agency involved in the medical emergency treatment.

**Please Print Clearly**

Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Address: \_\_\_\_\_ Cell: \_\_\_\_\_  
 City, State, Zip: \_\_\_\_\_  
 Email Address: \_\_\_\_\_

**In the event of an emergency, please notify:**

Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Alt. Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Alt. Phone: \_\_\_\_\_

**Physician's Name:** \_\_\_\_\_ Specialty: \_\_\_\_\_  
 Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_  
 Phone: \_\_\_\_\_

**Preferred Medical Facility/Hospital:** \_\_\_\_\_ Phone: \_\_\_\_\_  
 Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

**Health Insurance Company Name:** \_\_\_\_\_ Policy Holder: \_\_\_\_\_  
 Grp Nbr: \_\_\_\_\_ Policy Nbr: \_\_\_\_\_  
 Allergies: \_\_\_\_\_

**Consent Plan**

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

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

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

**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 volunteering or while being on the property of WCR, Inc. In the event that emergency treatment/aid is required, I wish the following procedure to take place:

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

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

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

**Confidentiality Agreement**

I understand that all information (written and verbal) about participants at this PATH Intl. Center is confidential and will not be shared with anyone without the expressed written consent of the participant and his/her guardian in the case of a minor.

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

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