

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: _____ Home: _____
 Address: _____ Cell: _____
 City, State, Zip: _____
 Email Address: _____
 Allergies: _____

In the event of an emergency, please notify:

Name: _____ Relation: _____ Home: _____
 Cell: _____
 Name: _____ Relation: _____ Home: _____
 Cell: _____

Physician's Name: _____
 Address: _____ City, State, Zip: _____
 Phone: _____

Preferred Medical Facility/Hospital: _____ Phone: _____
 Address: _____ City, State, Zip: _____

Health Insurance Company Name: _____ Policy Holder: _____
 Grp Nbr: _____ Policy Nbr: _____

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. *This consent will expire from year from the date given below.*

 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: _____