WILLOW CREEK RANCH, INC.
Therapeutic Riding Center

PATH INTERNATIONAL
Professional Association of Therapeutic Horsemanship International
Ensuring excellence and changing lives through equine-assisted activities and therapies

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: _____

Current Medication & Dosage: _____

_____

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: _____