ALL STAR EQUESTRIAN FOUNDATION, INC.
P. O. BOX 892
MANSFIELD, TEXAS 76063
817-477-1437 FAX: 817-473-9175
Website: allstarfoundation.

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

(TO BE COMPLETED ANNUALLY)

Name _____Date of Birth ____/___/____ Age _____

Parent or Legal Guardian (if under 18 years of age) _____

Address _____City_____State_____ Zip _____

Home Phone _____Cell Phone _____ Work Phone _____

Email address (please print) _____

Medical Diagnosis or Special Concerns _____

Physician _____Phone _____Hospital _____

Health Insurance Provider _____Policy # _____

Allergies to Medications: _____

Current medications _____

Medical condition requiring special precautions _____

IN THE EVENT OF AN EMERGENCY, CONTACT

Name _____Relation _____Phone _____

Name _____Relations_____ Phone _____

CONSENT PLAN

In the event of an emergency medical aid/treatment is required due to illness or injury during the process of receiving services or while being on the property of this agency in any type capacity, I authorize ALL STAR EQUESTRIAN FOUNDATION, INC. to:

1. Secure and retain medical treatment and transportation if needed
2. Release client records upon request to authorized individual or agency involved in the medical emergency treatment. This authorization includes but is not limited to: x-ray, surgery, hospitalization, medication and/or any treatment procedure deemed "life saving" by the physician or attending medical personnel. This provision will only be invoked if the person or persons named above are unable to respond or if the parent or legal guardian named above is unable to be reached.

Signature _____Date _____
Rider/Volunteer (or Parent/Guardian if under 18 years of age)

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 this agency.

1. Parent, legal guardian, or person authorized to make medical decisions for me will remain on site at all times during equine assisted or related activities.
2. In the event of emergency treatment/aid is required; I wish the following procedure to take place:

Signature _____Date _____
Rider/Volunteer (or Parent/Guardian if under 18 years of age)

REVISED June 20, 2012

PLEASE NOTE REVERSE SIDE MUST BE COMPLETED