



P. O. Box 376 Barrington, IL 60011- 0376 Office : (847) 381-4231

**Authorization for Emergency Medical Treatment Form  
Participant**

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Phone: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Physician's Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Preferred Medical Facility: \_\_\_\_\_

Health Insurance Company: \_\_\_\_\_ Policy #: \_\_\_\_\_

Allergies to Medication: \_\_\_\_\_

Current Medications: \_\_\_\_\_

In the event emergency medical aid/treatment is required due to illness or injury during the process of volunteering, or while being on the property of the agency, I authorize **Walk On** to:

1. Secure and retain medical treatment and transportation if needed.
2. Release participant records upon request to the authorized individual or agency involved in the Medical emergency treatment.

***Please sign only one below:***

**Consent Plan**

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 emergency contact is unable to be reached.

Date: \_\_\_\_\_ Consent Signature: \_\_\_\_\_  
*Participant, Parent, Guardian Signed in presence of staff*

**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 the agency.

- 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

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

Date: \_\_\_\_\_ Non-Consent Signature: \_\_\_\_\_  
*Participant, Parent, Guardian Signed in presence of staff*