



# Hilltop Therapeutic Riding Program, Inc.

## AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

\_\_\_\_\_ Participant      \_\_\_\_\_ Staff      \_\_\_\_\_ Volunteer

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

Physician's Name: \_\_\_\_\_ Preferred Medical Facility: \_\_\_\_\_

Health Insurance Co: \_\_\_\_\_ Policy #: \_\_\_\_\_

Current Allergies, Medications, and Health Concerns: \_\_\_\_\_

### IN THE EVENT OF EMERGENCY:

Emergency Contact 1: \_\_\_\_\_ Relation: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Emergency Contact 2: \_\_\_\_\_ Relation: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

In the event that emergency medical aid/treatment is required due to illness or injury during the process of receiving services, or while being on the property of the agency, I authorize **HILLTOP THERAPEUTIC RIDING PROGRAM, INC.** to:

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

### 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 person(s) listed cannot be reached.**

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

*Client, Parent, or Legal Guardian*

### NON-CONSENT PLAN:

I do not give 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 the agency. In the event emergency treatment/aid is required, I wish the following procedures to take place (please give details below):

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

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

*Client, Parent, or Legal Guardian*

**Hilltop  
Therapeutic Riding Program, Inc.**

**CONSENT FOR RELEASE OF INFORMATION**

I hereby authorize \_\_\_\_\_  
*Person(s) or Place(s) releasing information*

to release information from the records of \_\_\_\_\_,  
*Participant's name*

DOB: \_\_\_\_\_.

The information is to be released to Hilltop Therapeutic Riding Program, Inc. for the purpose of developing an equine activity program for the above-named participant. The information to be released is marked below.

\_\_\_\_\_ Medical History

\_\_\_\_\_ Physical Therapy evaluation, assessment and program plan

\_\_\_\_\_ Occupational Therapy evaluation, assessment and program plan

\_\_\_\_\_ Speech Therapy evaluation, assessment and program plan

\_\_\_\_\_ Psychosocial evaluation, assessment, program plan, discharge summary

\_\_\_\_\_ Classroom Individual Education Plan (I.E.P.)

\_\_\_\_\_ Cognitive-Behavioral Management Plan

\_\_\_\_\_ Other: \_\_\_\_\_

Date: \_\_\_\_\_ Signature: \_\_\_\_\_  
*Client, Parent or Legal Guardian*

Please send the indicated material to Hilltop Therapeutic Riding Program, Inc. at the address below. Thank you!