



WISH UPON A HORSE
 THERAPEUTIC RIDING CENTER
 190 Greenwood Drive, Hilton Head Island, SC 29928
 843.671.2586 tel • 843.671.2582 fax
 www.wishuponahorsehhi.org

Authorization of Emergency Medical Treatment Form

Participant (Parent or Legal Guardian) Volunteer Staff

In the event 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 Wish Upon a Horse, Inc. (“WUAH”) to secure and retain medical treatment and transportation, if needed. I further authorize WUAH to release client records upon request to the authorized individual or agency involved in the medical emergency treatment.

Participant Name:	Phone:	Phone:
Address:	City:	State/Zip:
If I cannot be reached Contact:	Phone:	Phone:
Alternate Emergency Contact:	Phone:	Phone:
Physician's Name:	Phone:	
Preferred Medical Facility:	Alternative:	
Health Insurance Company:	Policy #:	Group #:

Consent Plan

I authorize medical treatment including x-ray(s), surgery, hospitalization, medication and any treatment procedure deemed “life saving” by the physician. This provision will only be invoked if the person below is unable to be reached.

Date: _____ Consent Signature _____
(Client, Parent or Guardian)

OR
 Witness _____
(Staff Member of Wish Upon a Horse)

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 the agency. In the event emergency treatment/aid is required, I wish the following procedures to take place:

Date: _____ Consent Signature _____
(Client, Parent or Guardian)

Witness _____
(Staff Member of Wish Upon a Horse)