THE RIGHT STEP, INC.
THE HEALING POWER OF HORSES
A PATH Intl. Premier Therapeutic Riding Program

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

(Must be completed by parent/guardian if under 18 or unable to sign legal documents)

Name: ______________________________ DOB: ________________________

Home Phone:______________________ Cell Phone: _________________________

Address: ____

Physician: ____________________ Preferred Medical Facility: __________________

Health Insurance Co.: __________________ Policy Number: ____________________

Allergies to Medications: ____

Current Medications: ____

In the event of an emergency, contact:

1. Name: ________________ Relation: ___________Phone: ____________
2. Name: ________________ Relation: ___________Phone: ____________

Consent Plan

In the event emergency medical aid/treatment is required due to illness or injury while participating in a program of The Right Step, Inc., I authorize The Right Step, Inc. to:

1. Secure and retain medical treatment and transportation as deemed necessary.
2. Release appropriate records to the authorized individual/agency involved in the medical emergency treatment.

This authorization includes medical imaging, surgery, hospitalization, medication and any treatment procedure deemed "life saving" by a physician. This provision will only be invoked if a person above is unable to be reached.

____________________________________ ________________________

Consent Signature (Signed in presence of TRS rep) Date

Non-consent Plan

I **do not** give my consent for emergency medical treatment in the event of illness or injury while participating in a program of The Right Step, Inc. I agree that a parent or legal representative will remain on site all times during equine assisted activities. In the event emergency treatment or first aid is required, I wish the following procedures to take place:

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Non-consent Signature (Signed in presence of TRS rep) Date

9/10/15