

Stepping Stones Therapeutic Riding, Inc.

EMERGENCY TREATMENT

New Rider () Return Rider () School attending: _____

No individual can be accepted for riding instruction until this form has been completed by his/her parent(s) or guardian or by the individual if he/she is a legally competent adult, age 18 or over. Riding instructions will be under strict supervision, and although every effort will be made to avoid any accident, no liability can be accepted by any of the individuals or organizations concerned or by Stepping Stones Therapeutic Riding, Inc., its personnel, or affiliates.

Rider name: _____ Date of birth: _____

Address: _____ City: _____ State: _____ Zip _____

Phone: _____ Diagnosis: _____

Date of onset: _____ Age: _____ Height: _____ Weight: _____

Parent/Guardian name: _____ Phone: _____

Address: _____ City: _____ State _____ Zip _____

Previous riding experience: _____

Physician's name: _____ Phone _____

Address: _____ City: _____ State _____ Zip _____

Person who should be notified in case of emergency in absence of parent or guardian:

Name: _____ Phone: _____ Relationship: _____

TREATMENT AUTHORIZATION FOR PURPOSE OF PROVIDING MEDICAL

You are being asked to complete this form to give an appropriate medical facility permission to treat _____ (rider's name) for minor injury or medical problems. In the event of serious injury or illness, you will be contacted. Treatment will proceed before contacting you only if the situation is urgent and does not permit delay.

Preferred medical facility: _____

Is there a medical condition requiring special precaution or treatment? () yes () no

If yes, please describe: _____

Medications being used: () yes () no

If yes, please list dosage and description: _____

In case of medical emergency, the undersigned authorizes the Stepping Stones Therapeutic Riding, Inc., instructor and/or program coordinator to seek any medical and/or surgical treatment necessary for the care of _____ (rider's name), who is participating in the Stepping Stones Therapeutic Riding, Inc. program with parent/guardian permission and with the permission of his/her physician _____ (authorized signature).

I understand that no liability can be accepted by any individual or organization concerned with this program in the event of any accident, which may occur.

Health insurance: _____ Name of policyholder: _____

Name of company: _____ Policy number: _____

Name of policyholder's employer: _____

The above designated person(s) is (are) hereby authorized to incur medical costs necessary to provide medical treatment for said participant for which we shall be fully responsible. We also authorize the medical facility to release any and all information required to complete insurance claims and also authorize insurance payment directly to the medical facility.

Signature: _____

Date: _____

Witness: _____

Date: _____

Stepping Stones Therapeutic Riding, Inc.

NON-CONSENT PLAN/AUTHORIZATION FOR PURPOSE OF MEDICAL TREATMENT/AID

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.

- Parent or legal guardian will remain on site at all times during equine activities.
- In the event emergency treatment/aid is required, I wish the following procedure to take place:

Signature _____ Date: _____
Parent Guardian (circle appropriate one)

Witness _____ Date: _____

Procedure described as follows: