B.O.K. Ranch

Therapeutic Horseback Riding Center

Authorization for Emergency Medical Treatment

Name: _____ DOB: _____ Phone: _____

Street Address: _____

City/State/Zip: _____

Physician's Name: _____Phone: _____

Preferred Medical Facility: _____Phone: _____

Preferred Medical Facility Street Address: _____

Preferred Medical Facility City/State/Zip: _____

Health Insurance Company: _____ Policy #: _____

In the event of an emergency, contact:

Name: _____ Relationship: _____

Phone: (home/work) _____Cell phone: _____

Name: _____ Relationship: _____

Phone: (home/work) _____Cell phone: _____

Name: _____ Relationship: _____

Phone: (home/work) _____Cell phone: _____

In the event that emergency medical aid/treatment is required during training, I authorize B.O.K. Ranch to:

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

Consent Plan:

This authorization includes x-ray, surgery, hospitalization, medication and any treatment procedure deemed "lifesaving" by the physician. This provision will only be invoked if the person(s) listed above is unable to be reached in a timely manner.

Consent Signature: _____ Date: _____