

Heartland Therapeutic Riding, Inc.  
P.O. Box 391 Stilwell, KS 66085-0391  
Telephone: 913-897-3939  
Fax: 913-685-7433

## Volunteer's Authorization for Emergency Medical Treatment

In the event emergency medical aid/treatment is required due to illness or injury while riding or being on the property of Heartland Therapeutic Riding, Inc., I authorize Heartland Therapeutic Riding to secure and retain medical treatment and transportation, if needed.

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

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

In an emergency, please contact: \_\_\_\_\_ Phone: \_\_\_\_\_

OR: \_\_\_\_\_ Phone: \_\_\_\_\_

Physician's Name: \_\_\_\_\_

Preferred Medical Facility: \_\_\_\_\_

Health Insurance Company: \_\_\_\_\_ Policy No: \_\_\_\_\_

### Consent Plan

This authorization includes x-ray, surgery, hospitalization, medication and any treatment procedure deemed "life saving" by the physician.

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

Print Name: \_\_\_\_\_

### Non-Consent Plan

I do not give my consent for emergency medical treatment/aid in the case of illness or injury while riding or being on the property of Heartland Therapeutic Riding, Inc. In the event emergency treatment/aid is required, I will the following procedures to take place:

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

Print Name: \_\_\_\_\_