Authorization for Emergency Medical Treatment Form

Name: ______________________________ Date of Birth: ______________

Address: ____

City: ____________________ State: ______________ Zip: ____________

Home Phone: __________________ Work Phone: ____________________

Parent or Guardian if under 18 years of age: ____________________________

Address/Phone: ____

In case of emergency: Contact: __________________ Phone: ______________

Physician's Name: ______________________ _____Phone: _______________

Preferred Medical Facility: _______________________________________

Health Insurance Co.: ____________________ Policy #: ___________________

Health History: Please describe any other information that would be necessary for doctors to know about you should you need emergency services: ____________________________________

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Emergency Medical Treatment Consent Plan:
In the event emergency medical aid/treatment is required due to illness or injury during riding or volunteering with the MoonRise Farm program or while being on the property of MoonRise Farm. **I authorize** MoonRise Farm to secure and retain medical treatment and transportation if needed. This authorization includes x-rays, surgery, hospitalization, medication and any treatment procedure deemed " life saving" by the physician.

Consent Signature: Date:

Emergency Medical Treatment Non-Consent Plan:
Parent or legal guardian will remain on site at all times 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:

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I **do not give my consent** for emergency medical treatment/aid in the case of illness or injury.

Non-Consent Signature: Date:

WARNING: Under Vermont Law, an equine activity sponsor is not liable for an injury to, or the death of, a participant in equine activities resulting from the inherent risks of equine activities that are obvious and necessary, pursuant to 12 V.S.A. 1039.