

Hope Reigns Ranch

5201 Safford Rd.
Rockford, IL 61103
815-299-4673

**Authorization For
Emergency Medical Treatment Form**

In the event emergency medical aid/treatment is required due to illness or injury during the participation in activities with horses including horse back riding, or any other activities at Hope Reigns Ranch.. I authorize a representative of Hope Reigns Ranch to secure and retain medical treatment and transportation if needed for myself or my child.

In the event I cannot be reached, contact: _____ Phone: _____
Participants Name: _____ Phone: _____

Address: _____

Physician's Name: _____

Preferred Medical Facility: _____ Health

Insurance Co: _____ Policy #: _____

Consent Plan

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

Date: _____ Consent Signature: _____
(participant, Parent or Guardian)

Print Name: _____

_____ Phone: _____

Address: _____

Non-Consent Plan

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. In the event emergency treatment/aid is required, I wish the following procedures to take place:

Date _____ Non-Consent Signature _____

(Participant, Parent or Guardian)

Name (Print): _____ Phone: _____

Address: