Whispers *of Hope Horse Farm*

Challenged Rider Emergency Medical Form

Rider's Name: _____ ☐ Minor ☐ Adult (over 18 years of age) DOB ___/__/___

Parent/Guardian (if minor): _____ Cell # _____

Home Phone: (_____) _____ Work Phone: (_____) _____

Physician's Name: _____

Insurance Carrier (if applicable): _____

Policy Number: _____

Preferred Medical Facility: _____

*** Emergency Contact**: _____

*** Relationship**: _____ Day Ph: (_____) _____ Eve Ph: (___) _____

Diagnosis: _____

Describe <u>any</u> medical conditions requiring special precautions or treatment and/or medications including dosage.

_____

I, _____ (Rider) ☐ am over 18 years of age **or** ☐ under the age of 18 years, and fully competent to sign this Emergency Medical Form which I have read and understand, or, if under age, Rider has obtained the signature of his/her parent/ guardian, who, by such signature, represents he/she has read and understands this form. No person can be a Rider until this form is completed.

In case of medical emergency or necessity, Rider/rider representative authorizes Whispers of Hope to seek or provide for Rider such medical assistance as may be necessary or advisable and further authorizes Whispers of Hope to seek the assistance of any physician or medical facility to provide any medical/surgical care, including but not limited to, hospitalization, with such treatment to include anesthesia as necessary or advisable, that the physician or medical facilities deem or determines to be necessary or advisable, pending receipt by the physician or medical facility of any other consent to treatment from or on behalf of Volunteer.

Riding instruction will be under strict supervision, and, although every effort will be made to avoid any accident, Rider understand that NO LIABILITY can be accepted by any of the organizations concerned, including Whispers of Hope Horse Farm and the facility, in the event such accident may occur. In the event any provision of this form is determined to be unenforceable, all other provisions shall remain in full force and effect.

Consent Plan:

This authorization includes X-ray, surgery, hospitalization, medication and any treatment procedure deemed "life savings by the physician. This provision will only be invoked if the person below is unable to be reached.

Date: _____ Consent Signature: _____
(Please check ☐ volunteer age 18 or over, ☐ Parent, or ☐ Guardian)

Print Name: _____ Phone # best to reach you _____

(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 service or while being on the property of the agency. In the event emergency treatment/aid is required, I wish the following procedures take place: _____

Date: _____ Consent Signature: _____
(Please check ☐ volunteer age 18 or over, ☐ Parent, or ☐ Guardian)

Print Name: _____ Phone # best to reach you _____