

**Oak Hill Farm**  
**Therapeutic Riding**  
by Brenda Malcolm  
NARHA Certified Riding Instructor

4982 E. Station Road      oakfarm49@yahoo.com  
Roanoke, IN 46783      www.oakhillfarm.org  
(260) 672-8199

**Authorization for Emergency Medical Treatment**

In the event emergency medical aid/treatment is required due to illness or injury during the process of receiving services, or while being on the property of the agency, I authorize Oak Hill Farm to:

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

Client's Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

In the event I cannot be reached, Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

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

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

Health Insurance Co.: \_\_\_\_\_ Policy #: \_\_\_\_\_

**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 listed is unable to be reached.

Date: \_\_\_\_\_ Consent Signature \_\_\_\_\_  
[Client (over 18 yrs. of age), 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: \_\_\_\_\_  
[Client (over 18 yrs. of age), Parent or Guardian]

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

Address: \_\_\_\_\_