



Therapeutic Horseback  
Riding Program

## Volunteer's Authorization for Emergency Treatment Form

In the event emergency medical treatment is required due to illness or injury during the process of receiving services, or while being on the property of the Rainbow Connection, I authorize the Rainbow Connection to secure and retain medical treatment and transportation if needed.

Volunteer's Name: \_\_\_\_\_

Address: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Parent/Guardian (if under 18): \_\_\_\_\_

Emergency contact #1: \_\_\_\_\_ Phone: \_\_\_\_\_

Emergency contact #2: \_\_\_\_\_ Phone: \_\_\_\_\_

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. This provision will only be invoked if the person below is unable to be reached.

Date: \_\_\_\_\_ Consent signature: \_\_\_\_\_

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

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Date: \_\_\_\_\_ Consent signature: \_\_\_\_\_

(Volunteer, Parent or Guardian)

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

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