Destiny 's Ride
Therapeutic Horseback Riding Program
PO Box 695 ~ Lee, Ma 01240

Participant's Authorization for Emergency Medical Treatment Form

Participant's Name: _____ DOB: _____ Phone: _____
Address: _____
Family Email Address: _____

In the event of an emergency contact:
Name: _____ Phone: _____ Relationship: _____
Name: _____ Phone: _____ Relationship: _____

Physician's Name_____Telephone_____
Preferred Medical Facility: _____
Health Insurance Co.: _____Policy #:_____

Allergies to medications: _____
Current medications: _____
State any information that you want supplied to a medical professional treating you in an emergency: _____
_____

Consent Plan

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 premises operated by Destiny's Ride Therapeutic Horsemanship Center, Inc, I authorize Destiny's Ride Therapeutic Horsemanship Center, Inc. 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.**

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: _____
Participant (Parent or Guardian if participant is under the age of 18 yrs)
Print Name: _____ Relationship to Rider _____ 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. Therefore, check one of the following:
_____ ***A parent or legal guardian will remain on site at all times during equine assisted activities.***
_____ ***In the event emergency treatment/aid is required; I wish the following procedures to take place:***
_____

Date: _____Non-Consent Signature: _____
Participant (Parent or Guardian if participant is under the age of 18 yrs)
Print Name: _____ Relationship to Rider _____ Phone: _____
Address: _____

**** A COPY OF THE COMPLETED MEDICAL HISTORY SHOULD BE ATTACHED TO THIS FORM****

UNDER MASSACHUSETTS LAW, AN EQUINE PROFESSIONAL IS NOT LIABLE FOR AN INJURY TO, OR THE DEATH OF, A PARTICIPANT IN EQUINE ACTIVITIES RESULTING FROM THE INHERENT RISKS OF EQUINE ACTIVITIES, PURSUANT TO CHAPTER 128-SECTION 2D OF THE GENERAL LAWS.