

RHYTHM OF THE REIN THERAPEUTIC RIDING PROGRAM



PO Box 67 386 US Rt.2 Marshfield, Vt. 05658 802 426 3781

[RhythmOfTheRein@aol.com](mailto:RhythmOfTheRein@aol.com)

\_\_\_ Participant \_\_\_ Staff \_\_\_ Volunteer

Name \_\_\_\_\_ DOB \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

Physicians Name \_\_\_\_\_ Phone \_\_\_\_\_

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

Health Insurance \_\_\_\_\_ Policy # \_\_\_\_\_

Allergies \_\_\_\_\_

Current Medications \_\_\_\_\_

In case of emergency contact

Name \_\_\_\_\_ Relations \_\_\_\_\_ Phone \_\_\_\_\_

Name \_\_\_\_\_ Relation \_\_\_\_\_ Phone \_\_\_\_\_

In the event emergency medical aide/treatment is required due to illness or injury during the process of receiving services, or whiel being on the property of the agency, I authorize Rhythm of the Rein or Water Tower 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 emergency medical treatment.

CONSENT PLAN

This authorization includes x-ray, surgery, hospitalization, medication and any treatment procedures deemed "life saving" by the physician. This provision will only be invoked the person(s) above are unable to be reached.

Consent Signature \_\_\_\_\_ Date \_\_\_\_\_

(client, parent, or legal guardian – *signed in presence of center staff*)

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.

\_\_\_ Parent or legal guardian will remain on site at all times during equine assisted activities

\_\_\_ In the event emergency treatment is required, I wish the following procedures to take place:

Consent Signature \_\_\_\_\_ Date \_\_\_\_\_

(client, parent, or legal guardian, *signed in presence of center staff*)