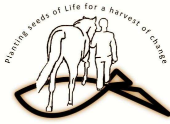

EMERGENCY MEDICAL TREATMENT AUTHORIZATTION

Participant Name	Address	Phone Number
Date of Birth	Age	Parents/Caregiver
Diagnosis		Date of Onset

CONSENT PLAN
In the event emergency medical aid or treatment is required due to illness or injury during the process of receiving services, or while at the Center/Program, I authorize 4 Seasons Therapeutic Equestrian Program (4STEP) to: 1. secure and retain individual or agency involved in the medical treatment and transportation if needed; 2. release participant 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 be invoked if the person listed below is unable to be reached.

Date	Consent Signature (participant, Parent/Guardian)
Name of Emergency Contact	Phone Number of Emergency Contact
Address	
Alternate Contact	Phone Number of Alternate Contact
Preferred Medical Facility	Physician's Name
Health Insurance Co	Policy Number

Non-Consent Plan
I do not give my consent for emergency medical treatment or aid in the case of illness or injury during the process of receiving services, or while at the Center/Program. In the event emergency treatment or aid is required, I wish the following procedures to take place:

Date	Non-Consent Signature
Phone Number	Print Name
Address	

4STEP 60 Four Seasons Lane McClure, PA 17009 717.543.5901

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