

# Equi-Ed

## Equines and Education

Mailing address: 1535 Farmer's Lane #217 Santa Rosa, CA 95405

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### STAFF/VOLUNTEER/STUDENT/GUEST/PARTICIPANT EMERGENCY HEALTH INFORMATION

In the event emergency medical aid/treatment is required due to illness or injury during the process of participating in services/activities, or while being on the property of the agency, I authorize Equi-Ed/SRJC to:

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

Name: \_\_\_\_\_ Phone # \_\_\_\_\_

Parent/Guardian/Spouse/Other (specify relationship \_\_\_\_\_) \_\_\_\_\_

Address \_\_\_\_\_ City : \_\_\_\_\_ Zip \_\_\_\_\_

Allergies: \_\_\_\_\_

Medications: \_\_\_\_\_

Please describe any other medical conditions/physical limitations that we or medical personnel should be aware of i.e. seizures, diabetes, etc.:

\_\_\_\_\_

#### Emergency Contacts:

Name \_\_\_\_\_ Phone (H) \_\_\_\_\_ Phone (W) \_\_\_\_\_

Name \_\_\_\_\_ Phone (H) \_\_\_\_\_ Phone (W) \_\_\_\_\_

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

Preferred medical facility \_\_\_\_\_

Insurance Company \_\_\_\_\_ Phone \_\_\_\_\_

Full Address \_\_\_\_\_

Group # \_\_\_\_\_ Policy # \_\_\_\_\_

Medi-Care # \_\_\_\_\_ Medi-Cal # \_\_\_\_\_

\*\*\*\*\*SIGNATURE NEEDED BELOW\*\*\*\*\*

#### 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 listed below is unable to be reached.

**Consent signature** (self/parent/guardian) \_\_\_\_\_ Date: \_\_\_\_\_

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

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

#### OR

#### Non-Consent Plan

I do not give my consent for emergency medical treatment/aid in the case of illness/injury during the process of participating in the services or while on the property of the agency. In the event emergency treatment/aid is required, I wish the following procedures to take place:

\_\_\_\_\_

**Non-Consent Signature** (self/parent/guardian) \_\_\_\_\_ Date: \_\_\_\_\_

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

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