



CARLISLE ACADEMY
INTEGRATIVE EQUINE
THERAPY & SPORTS

2017 STUDENT AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

NAME: _____ DOB: _____
ADDRESS: _____
EMAIL: _____ Phone #1 _____ Phone #2 _____

Physician's Name: _____ Preferred Medical Facility: _____
Primary Health Insurance#1: _____ Policy #: _____
Secondary Health Insurance #2: _____ Policy #: _____
Primary Care Physician: _____ Telephone #: _____
Allergies to medication or other known allergies: _____

Current medications/dosing/side effects: _____

In the event of an emergency contact:

Name: _____ Phone #1: _____ Phone#2: _____
Name: _____ Phone #1: _____ Phone#2: _____
Name: _____ Phone #1: _____ Phone#2: _____

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 property of Spring Creek Farm, I authorize Carlisle Academy 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.

This authorization includes x-ray, surgery, hospitalization, medication and any treatment procedure deemed life saving and medically necessary by the treating physician. This provision will only be invoked if the person (s) above is unable to be reached.

Date: _____ Consent Signature: _____
(To be signed in the presence of staff by Student or Legal Guardian)

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 being on the property of Spring Creek Farm.

- 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 procedure to take place:

 I have advanced directives and a copy of this is with:

Date: _____ Consent Signature _____
(To be signed in the presence of staff by Student or Legal Guardian)