EMERGENCY MEDICAL TREATMENT

(This form must be updated annually or more frequently if needed)

Name: ____ DOB: ____________________

Participants Diagnosis: ____

Describe any medical conditions requiring special consideration, including allergies or seizures, and current medications and dosage:

Physician's Name: ______________________________ Phone: ______________________

PREFERRED Medical Facility: ____

Emergency Contact Information:

Name: __________________ Relation: __________________ Phone: __________________

Name: __________________ Relation: __________________ Phone: __________________

Name: __________________ Relation: __________________ Phone: __________________

In the event emergency medical aid/treatment is required due to illness or injury while riding or being on the property of Due West Therapeutic Riding Center, I authorize Due West Therapeutic Riding Center to secure and retain medical treatment and transportation, if needed.

Please choose one:

__________ **I CONSENT to the above stated emergency medical procedures**

__________ **I DO NOT CONSENT to the above emergency medical procedures**

____ Date: ____________________

Signature of Adult Participant or Parent/Guardian if under 18

____ ____________________

Medical Insurance Carrier Policy Number

Please return completed application to:

13400 Donahoo Road | Kansas City, Kansas | 66109 | (913) 244-2771 | (913) 620-2940
Visit our NEW website:
www.duewesttrc.org
a 501(c)(3) Organization