



TRINITY

HORSE FARM LLC

2536 Columbia Rd., Medina, OH 44256

Phone: 330-483-3601

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

_____ **Participant** _____ **Staff** _____ **Volunteer**

Name: _____ DOB: _____ Phone: _____

Address: _____

Physician's Name: _____

Allergies to medications: _____

In the event of an emergency, contact:

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

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 **Trinity Horse Farm LLC ("Trinity")**, the undersigned authorizes **Trinity and/or any of its representatives to:**

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

Date: _____ Consent Signature: _____

(Client, Parent or Legal Guardian)

Non-Consent Option

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 or leased properties of Trinity. In the event that emergency treatment/aid is required, I wish the following procedures to take place:

Date: _____ Consent Signature: _____

(Client, Parent or Legal Guardian)