



Mounted Dream Center, INC.

P.O. Box 854
Sonora, California 95370
209.533.8930

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

In the event emergency medical treatment is required due to illness or injury during the process of receiving services, or while being on the property of the agency, I authorize **Mounted Dream Center** 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 medical emergency treatment.

Client's Name: _____ Phone: _____

Address: _____

In the event I cannot be reached, contact: _____ Phone: _____

contact: _____ Phone: _____

Physician's Name: _____ Phone: _____

Preferred Medical Facility: _____

Health Insurance Co.: _____ Policy#: _____

CONSENT PLAN

This authorization includes x-rays, 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.

Date: _____ Consent Signature: _____

(CLIENT, PARENT, GUARDIAN)

Print Name: _____ Phone: _____

Address: _____

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 while being on the property of the agency. In the event emergency treatment / aid is required, I wish the following procedures to take place:

Date: _____ Consent Signature: _____

(CLIENT, PARENT, GUARDIAN)

Print Name: _____ Phone: _____

Address: _____

A COPY OF THE COMPLETED MEDICAL HISTORY SHOULD BE ATTACHED TO THIS FORM.