ADMINISTRATIVE OFFICE
20015 GREAT FALLS FOREST DRIVE
GREAT FALLS, VIRGINIA 22066

info@projecthorse.org

SERVICES & EQUINE FACILITY
18915 LINCOLN ROAD
PURCELLVILLE, VIRGINIA 20132

(703) 517-6964

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

Name: ______________________________ DOB: ______________ Phone: ____________________

Address: ____

Physician's Name: ___________________________ Medical Facility: ___________________________

Health Insurance Co: ________________________________ Policy #: _______________________

Allergies to Medications: ____

Current Medications: ____

In the event of an emergency, contact:

Name: ______________________________ Relation: ______________ Phone: ______________

Name: ______________________________ Relation: ______________ Phone: ______________

Name: ______________________________ Relation: ______________ 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 Project Horse or Trillium Farm LLC, I authorize Project Horse 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.

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(s) above is unable to be reached.

Consent Signature: ____ Date: ________________

Client (or Parent / Legal Guardian, if client is a minor)

☐ **Signed in the presence of program personnel**

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 Project Horse or Trillium Farm LLC. In the event emergency treatment/aid is required, I wish the following procedures to take place:

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Non-Consent Signature: _____________________________________ Date: ________________

Client (or Parent / Legal Guardian, if client is a minor)

☐ **Signed in the presence of program personnel**