

EQUI-ANGELS
4809 Trouble Creek Rd, New Port Richey, FL 34652
Phone (727) 815.8100, E-mail: Info@Equi-Angels.org

WARNING

UNDER FLORIDA LAW, AN EQUINE ACTIVITY SPONSOR OR EQUINE PROFESSIONAL IS NOT LIABLE FOR AN INJURY TO, OR THE DEATH OF, A PARTICIPANT IN EQUINE ACTIVITIES DUE TO THE INHERENT RISKS OF EQUINE ACTIVITIES.

Participant/Rider's Authorization for Emergency Medical Treatment Form

In the event of emergency medical aid/treatment is required due to illness or injury during the process of receiving services from Equi-Angels, I authorize staff from Equi-Angels to:

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

Participant/Rider _____
Print Name Signature Date

Parent/Guardian _____
(If participant/Rider is under 18 years age) Signature Date

Address _____
Street City State Zip

Home Phone _____ Work Phone _____

Physician's Name _____ Physician's Phone _____

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 Guardian/Parent or Emergency Contact is unable to be reached.

Initial one: _____ Yes _____ No

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 from Ruth E. Squires.

Initial one: _____ Yes _____ No

In the event emergency treatment/aid is required, I wish the following procedures to take place:

EMERGENCY CONTACTS

1) Name _____ Relationship to Participant/Rider _____

Day Phone _____ Evening Phone _____

Address _____

2) Name _____ Relationship to Participant/Rider _____

Day Phone _____ Evening Phone _____

Address _____

INSURANCE INFORMATION

Is the Participant/Rider covered by Medicaid? Initial one: _____ Yes _____ No

Is the Participant/Rider covered by medical/hospital insurance? Initial one: _____ Yes _____ No

Health Insurance Co _____ Group # _____

Carrier address _____

Name of Insured _____

Social security number of policy holder or insurance ID number _____