Hope Farms Project
Authorization for Emergency Medical Treatment Form

Circle One: Participant Staff Volunteer

Name: _____DOB:_____Phone:_____
Address:_____
Physician's Name: _____ Preferred Medical Facility:_____
Health Insurance Company: _____Policy #: _____
Allergies to medications: _____
Current medications: _____

In the event of emergency, contact:
Name: _____Relation:_____Phone: _____
Name: _____Relation:_____Phone: _____
Name: _____Relation:_____Phone: _____

Consent Plan
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 the organization, I authorize Hope Farms Project 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
1. This authorization includes x-ray, surgery, hospitalization, medication and any treatment procedure deemed "life saving" by the physician. This provision will only be involked if the person(s) above is unable to be reached.

Date: _____ Consent Signature: _____
Client, Parent or Legal Guardian
Signed in presence of HFP staff

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 organization.
___ Parent or legal guardian will remain on site at all times during animal assisted activities
___ In the event of emergency treatment/aid is required, I wish the following procedure to take place:
_____
_____

Date: _____ Non-Consent Signature: _____
Client, Parent or Legal Guardian
Signed in presence of HFP staff