VICTORY
THERAPY CENTER

PATH INTERNATIONAL
Professional Association of Therapeutic Horsemanship International
PREMIER ACCREDITED CENTER

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

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 agency, I authorize: Victory Therapy Center to:

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

Physician's Name:

_____

Preferred Medical Facility:

_____

Insurance:

_____

Designated Person: _____ 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 the person below is unable to be reached.

Consent Signature: _____ Date: _____/_____/_____
Client (parent or guardian if minor client)

Print Name: _____ Phone: _____

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:

_____

_____

Non-Consent Signature: _____ Date: _____/_____/_____
Client (parent or guardian if minor client)

Print Name: _____ Phone: _____

WARNING: UNDER TEXAS LAW (CHAPTER 87, CIVIL PRACTICE & REMEDIES CODE) A FARM ANIMAL PROFESSIONAL IS NOT LIABLE FOR AN INJURY TO OR THE DEATH OF A PARTICIPANT IN FARM ANIMAL ACTIVITIES RESULTING FROM THE INHERENT RISKS OF FARM ANIMAL ACTIVITIES.