

Stirrups 'n Strides Therapeutic Riding Center, Inc.

VOLUNTEER/PERSONNEL EMERGENCY RELEASE TREATMENT FORM

(PLEASE PRINT)

Volunteer/Personnel Name _____ Date _____

Address: _____ City: _____ State _____ Zip: _____

Telephone #: _____

Physician's Name: _____

Physician's Telephone #: _____

Health Care Insurance Co: _____ Policy #: _____

IN CASE OF AN EMERGENCY WHO SHALL WE CONTACT?

Name _____ Relationship _____

Telephone # _____ Work # _____

Preferred Medical Facility: _____

Do you have any medical condition requiring any special precautions or treatment? Allergies?

None _____ If so, please describe: _____

List medications and dosages: _____

In case of an emergency, the undersigned authorizes Stirrups 'n Strides Therapeutic Riding Center, Inc to provide such medical assistance as they determine to be necessary.

In the event that the preferred physician (above) cannot be reached, the undersigned authorizes any licensed physician and/or medical facility to provide any medical/surgical care and/or hospitalization for the participant, including anesthetic, which they determine necessary or advisable, pending receipt of a specific consent from the undersigned.

Signature of Volunteer/Personnel _____ Date _____

Signature of Parent/Guardian if under Age 18 _____

Sworn to (or affirmed) and subscribed before me this ____ day of _____, 2007

By _____

Notary Public – State of Florida

(AFFIX NOTARY SEAL HERE)

Personally Known _____

or

Produced Identification _____

Drivers License # _____