



Dream Catchers
at the Cori Sikich Therapeutic Riding Center

P. O. Box 1261
Williamsburg, Virginia 23187-1261
757-566-1775
info@dreamcatcherswilliamsburg.org

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

CONSENT FOR EMERGENCY MEDICAL TREATMENT

In the event emergency medical aid/treatment is required due to illness or injury while being on the premises of or in connection with Dream Catchers, I authorize Dream Catchers and/or its representatives to:

1. Obtain medical treatment and /or transportation if needed;
2. Release records upon request to the authorized agency or its representative involved in the medical emergency treatment.

Name: _____ Telephone: _____

Address: _____ City/Zip _____

In the event of an emergency, contact:

Name: _____ Telephone: _____

Relationship: _____

Physician's Name: _____ Telephone: _____

Medical Facility: _____ Telephone: _____

Health Insurance Co.: _____ Policy: _____

In an effort to provide the best care possible, please indicate below:

I am allergic to the following medications: _____

I have the following ongoing medical conditions (e.g. diabetes, seizures): _____

Date: _____ Signature: _____

Parent/Guardian if under 18 years: _____

NON-CONSENT FOR EMERGENCY MEDICAL TREATMENT

I hereby **DO NOT** give my consent for emergency medical treatment in the case of illness or injury while on the premises of or in connection with Dream Catchers. In the event emergency treatment/aid is required, I wish the following procedure to take place:

Date: _____ Signature: _____

Print Name: _____ Telephone: _____

Address: _____ City/Zip: _____