



Ride On



Therapeutic Horsemanship

Send paperwork to Office@Rideon.org Or

Fax to 805 309 -5234

Rider's 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 Ride On Therapeutic Horsemanship 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.

Clients Name: _____ Date of Birth: _____ Height _____ Weight: _____

Address: _____

Email Address: _____ Phone: _____

In the event I cannot be reached; Contact: _____ Phone: _____

Physician's Name: _____

Preferred Medical Facility: _____

Health Insurance Co: _____ Policy #: _____

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.

Date: _____ Consent Signature: _____
Client, Parent or Guardian

Print Name: _____ Phone: _____

Address: _____

Place of Employment _____ Position _____

Non-Consent to Emergency Medical Treatment

I do not give consent for emergency medical treatment/aid in the case of illness or injury. In the event of an emergency I wish the following to take place: _____

Date: _____ Signature: _____

Photo Release I consent to and authorize/ I do NOT consent to and authorize the use and reproduction by Ride On Therapeutic Horsemanship of any and all photographs and any other audio-visual materials taken of me for promotional material, educational activities, exhibitions, social media or for any other use for the benefit of the program.

Date: _____ Signature: _____