A New Dawn Therapeutic Riding Program

1164 Blattdahl Road * Mohrsville, PA 19541 * 610-655-5271

EMERGENCY TREATMENT

Student: _____ Date of Birth: _____

Parent, Spouse, Guardian Name: _____

Address: _____
Street Address, City, State, Zip

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Physician: _____ Phone: _____

Physician Address: _____

Health Insurance Company: _____ Member ID# _____

Preferred Medical Facility: _____

Individual Authorized to give temporary assistance or care in the absence of parent/guardian:

Name: _____ Relationship: _____

Home Phone: _____Cell Phone: _____Work Phone:_____

Are there any medical conditions requiring special precautions or treatment and medications and dosage? NO YES

If yes, please describe: _____

_____

In case of a MEDICAL EMERGENCY, the undersigned authorizes A New Dawn Therapeutic Riding Program to provide such medical assistance as they deem necessary.

The undersigned authorizes any licensed physician and/or medical facility to provide any medical/surgical care and/or hospitalization for the student, including anesthetic, which they determine necessary or advisable, pending receipt of a specific consent from the undersigned.

Signed: _____ Date: _____
Client/Parent/Guardian