# Stepping Stones Therapeutic Riding, Inc.

## EMERGENCY TREATMENT

New Rider ( ) Return Rider ( ) School attending:_____
No individual can be accepted for riding instruction until this form has been completed by his/her parent(s) or guardian or by the individual if he/she is a legally competent adult, age 18 or over. Riding instructions will be under strict supervision, and although every effort will be made to avoid any accident, no liability can be accepted by any of the individuals or organizations concerned or by Stepping Stones Therapeutic Riding, Inc., its personnel, or affiliates.

Rider name:_____Date of birth:_____
Address:_____City:_____State:_____Zip___
Phone:_____Diagnosis:_____
Date of onset:_____Age:_____Height:_____Weight:_____

Parent/Guardian name:_____Phone:_____

Address:_____City:_____State_____Zip___
Previous riding experience:_____
Physician's name:_____ Phone_____
Address:_____City:_____State_____Zip___

Person who should be notified in case of emergency in absence of parent or guardian:
Name:_____Phone:_____Relationship:_____

## TREATMENT AUTHORIZATION FOR PURPOSE OF PROVIDING MEDICAL

You are being asked to complete this form to give an appropriate medical facility permission to treat _____ (rider's name) for minor injury or medical problems. In the event of serious injury or illness, you will be contacted. Treatment will proceed before contacting you only if the situation is urgent and does not permit delay.
Preferred medical facility: _____
Is there a medical condition requiring special precaution or treatment? ( ) yes ( ) no
If yes, please describe: _____
Medications being used: ( ) yes ( ) no
If yes, please list dosage and description: _____
In case of medical emergency, the undersigned authorizes the Stepping Stones Therapeutic Riding, Inc., instructor and/or program coordinator to seek any medical and/or surgical treatment necessary for the care of _____ (rider's name), who is participating in the Stepping Stones Therapeutic Riding, Inc. program with parent/guardian permission and with the permission of his/her physician _____ (authorized signature).

I understand that no liability can be accepted by any individual or organization concerned with this program in the event of any accident, which may occur.

Health insurance:_____ Name of policyholder:_____
Name of company:_____ Policy number: _____
Name of policyholder's employer:_____

The above designated person(s) is (are) hereby authorized to incur medical costs necessary to provide medical treatment for said participant for which we shall be fully responsible. We also authorize the medical facility to release any and all information required to complete insurance claims and also authorize insurance payment directly to the medical facility.

Signature:_____ Date:_____

**Witness:** _____ Date:_____