



# Destiny's Ride

Therapeutic Horseback Riding Program  
PO Box 695 ~ Lee, Ma 01240

## Participant's Authorization for Emergency Medical Treatment Form

Participant's Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Phone: \_\_\_\_\_  
Address: \_\_\_\_\_  
Family Email Address: \_\_\_\_\_

### In the event of an emergency contact:

Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

Physician's Name \_\_\_\_\_ Telephone \_\_\_\_\_  
Preferred Medical Facility: \_\_\_\_\_  
Health Insurance Co.: \_\_\_\_\_ Policy #: \_\_\_\_\_

Allergies to medications: \_\_\_\_\_  
Current medications: \_\_\_\_\_  
State any information that you want supplied to a medical professional treating you in an emergency: \_\_\_\_\_

### Consent Plan

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 premises operated by Destiny's Ride Therapeutic Horsemanship Center, Inc, I authorize Destiny's Ride Therapeutic Horsemanship Center, Inc. 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.

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: \_\_\_\_\_  
Participant (Parent or Guardian if participant is under the age of 18 yrs)

Print Name: \_\_\_\_\_ Relationship to Rider \_\_\_\_\_ Phone: \_\_\_\_\_  
Address: \_\_\_\_\_

### Non-Consent Plan

I do not give my consent for emergency medical treatment/aid in the case of illness or injury during the process of Receiving services or while being on the property of the agency. Therefore, check one of the following:

- \_\_\_\_\_ *A parent or legal guardian will remain on site at all times during equine assisted activities.*  
\_\_\_\_\_ *In the event emergency treatment/aid is required; I wish the following procedures to take place:*

Date: \_\_\_\_\_ Non-Consent Signature: \_\_\_\_\_  
Participant (Parent or Guardian if participant is under the age of 18 yrs)

Print Name: \_\_\_\_\_ Relationship to Rider \_\_\_\_\_ Phone: \_\_\_\_\_  
Address: \_\_\_\_\_

**\*\* A COPY OF THE COMPLETED MEDICAL HISTORY SHOULD BE ATTACHED TO THIS FORM\*\***

**UNDER MASSACHUSETTS LAW, AN EQUINE PROFESSIONAL IS NOT LIABLE FOR AN INJURY TO, OR THE DEATH OF, A PARTICIPANT IN EQUINE ACTIVITIES RESULTING FROM THE INHERENT RISKS OF EQUINE ACTIVITIES, PURSUANT TO CHAPTER 128-SECTION 2D OF THE GENERAL LAWS.**