**AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT OF PARTICIPANT**
Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: Click or tap to enter a date.Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Physician’s Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Preferred Medical Facility:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Health Insurance Co.:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Policy #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Allergies to Medications: Y[ ]  N[ ]  (If yes, what medications:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)
Current Medications:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Persons to be contacted in case of an emergency:
1. NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ RELATIONSHIP:Choose an item. PHONE: \_\_\_\_\_\_\_\_\_\_\_\_\_
2. NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ RELATIONSHIP:\_Choose an item. PHONE: \_\_\_\_\_\_\_\_\_\_\_\_\_
3. NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_RELATIONSHIP:Choose an item. PHONE: \_\_\_\_\_\_\_\_\_\_\_\_\_
In the event emergency medical treatment is required due to illness or injury during the process of receiving services or while on the property of the agency, I authorize the CLT Farms Equestrian Healing Center LLC, LLC. to: 1. Secure and retain medical treatment and transportation, if needed. 2. Release participant’s records upon request to the authorized individual or agency involved in the emergency treatment. Consent Plan: This authorization includes x-ray, surgery, hospitalization, medication and any treatment deemed “life saving” by the physician. This provision will only be invoked if the persons listed above are unable to be reached.
Consent Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: Click or tap to enter a date.
Signature of parent or guardian if participant is under 18 Non Consent Plan: (Parent or Legal Guardian must remain on site at all times during Equine Assisted Activities.) [ ] I ***do not*** give my consent for emergency medical treatment/aid in the case of illness or injury while on the property of the agency
Non Consent Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: Click or tap to enter a date.
Signature of parent or guardian if participant is under 18:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CONSENT FOR TREATMENT AND RELEASE OF LIABILITY**
Although every effort will be made to avoid accident of injury, NO LIABILITY can be accepted by any of the organizations concerned including CLTFEHC, its officers, trustees, agents, employees, each and every one of its members, volunteers or associates or the property owners upon whose land the therapy sessions are conducted. I request and consent to treatment that may include therapy and I have discussed this type of therapy with my/my child’s doctor.

**LIABILITY RELEASE** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Participant’s Name) would like to participate in CLTFEHC’s program. I acknowledge the risks and potential of risk for activities involving equines. I feel, however, that the possible benefits of Equine Assisted Activities to myself/my child, or my ward are greater than the risks assumed. I hereby, intending to be legally bound for myself, my heirs or assigns, executors or administrators, waive and release all claims for damages against CLTFEHC, LLC., its Board of Trustees, Employees, Instructors, Therapists, Aids, Volunteers, Equines, Equine Owners, Equipment or Operating Site or the Owners of CLT Farms Equestrian Healing Center LLC any and all injuries and/or losses I/my child/my ward may sustain while participating at CLTFEHC, LLC “WARNING UNDER Kentucky law a farm animal activity sponsor, a farm animal professional or other person does not have the duty to eliminate all risks of injury of participation in farm animal activities. There are inherent risks of injury that you voluntarily accept if you participate in farm animal activities.” I understand that no liability can be accepted by any of the organizations concerned with this therapy. Dated signatures of parent/guardian or participant of legal age must be included.
Participant’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: Click or tap to enter a date.