1347 55th Avenue
Amery, WI 54001
715-268-2168
Fax (715) 268-4560

Patti: 715-554-0748
Karole: 651-491-5945
Kristi: 715-410-3825

DATE RECEIVED _____

AUTHORIZATION OF EMERGENCY MEDICAL TREATMENT FORM

In the event emergency medical aid/treatment is required due to injury/illness during the process of receiving services, or while being on the property, I authorize Quarter Moon Acres, Inc. Equine Therapy Center to secure and retain medical treatment and transportation if needed and to release client records upon request of the authorized individual/agency involved in the medical emergency treatment.

CLIENT INFORMATION

NAME _____ M F DATE OF REGISTRATION _____

PARENT/GUARDIAN NAME (IF APPLICABLE) _____

ADDRESS _____

CITY _____ ZIP CODE _____

CONTACT: HOME _____ WORK _____

CELL _____ EMAIL _____

PREFERRED NUMBER _____

EMERGENCY CONTACT: NAME _____ PHONE _____

PHYSICIAN'S NAME _____ PHONE _____

MEDICAL FACILITY NAME _____ PHONE _____

HEALTH INSURANCE CO. _____ POLICY _____

CONSENT PLAN – THE 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 IS UNABLE TO BE REACHED.

_____ _____

CONSENT SIGNATURE (PARENT OR GUARDIAN) DATE:

_____ _____

PLEASE PRINT NAME: PHONE

PLEASE COMPLETE & SIGN OTHER SIDE

Client Medical History and Physician's Statement

Client's Name: Sex Age Date of Birth Height Weight

Name/Address of Guardian: Tetanus Shot: YES NO
Date:

Diagnosis: Date of Onset:

For those with Down Syndrome: Neurologic Symptoms of Atlanto-Axial Instability: ☐ Present ☐ Absent
Medications:

Mobility: Independent Ambulation: ☐ Yes ☐ No Assisted Ambulation: ☐ Yes ☐ No

Please indicate if patient has a problem and/or surgical history in any of the following areas:							
Area	Yes	No	Comments	Area	Yes	No	Comments
Auditory				Muscular			
Visual				Independent ambulation			
Speech				Crutches			
Allergies				Braces			
Cardiac				Wheelchair			
Circulatory				Neurological			
Balance				Orthopedic			
Learning Disability				Pulmonary			
Cognitive Impairment				Integumentary (Skin)			
Psychological Impairment				Other			
Seizures			Type:	Controlled:			Date of Last Seizure:

To my knowledge, there is no reason why this person cannot participate in supervised equestrian activities.

Physician's Signature:	Date of Last Exam:
Physician's Name: (Please Print)	Physician's Phone:
Address:	Physician's Fax: