FULL CIRCLE FARM
THERAPEUTIC HORSEMANSHIP

80 Edgell Road
Newport, NH 03773

603.863.1262
info@fcftherapeutic.org

fcftherapeutic.org

Authorization for Emergency Medical Treatment

_____Participant _____Staff _____Volunteer

Name: ____ DOB: ________ Phone: _____________
Physician's Name: _______________________ Preferred medical facility: _________________
Health insurance co: ______________________________ Policy #: _______________________
Current allergies, medications, and health concerns: __________________________________
____

In the event of an emergency:
Emergency contact 1: _________________________________ Relationship: _______________
Home Ph: ____________________ Work Ph: ___________________ Cell Ph: _______________
Emergency contact 2: _________________________________ Relationship: _______________
Home Ph: ____________________ Work Ph: ___________________ Cell Ph: _______________

In the event that emergency medical aid/treatment is required due to illness or injury during the process of receiving services, or while being on the property of the agency, I authorize Full Circle Farm 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.

CONSENT PLAN
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(s) listed cannot be reached.**

Date: ____________ Consent Signature ____

Client, Parent, or Legal Guardian

NON-CONSENT PLAN
I do not give consent for emergency medical aid/treatment in the case of illness or injury and agree to be present with the participant during the process of receiving services or while being at Full Circle Farm

Date: ____________ Consent Signature ____
Client, Parent, or Legal Guardian