

# Miracles in Motion

## Authorization for Emergency Medical Treatment

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 property located at 2049 – 120<sup>th</sup> Street, Swisher, Iowa, I authorize Miracles in Motion Therapeutic Equestrian Center 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.

Client's Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

In the event I cannot be reached, contact: \_\_\_\_\_ Phone: \_\_\_\_\_

contact: \_\_\_\_\_ Phone: \_\_\_\_\_

Client's Disability: \_\_\_\_\_

Physician's Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Preferred Medical Facility: \_\_\_\_\_

Health Insurance Co.: \_\_\_\_\_ Policy #: \_\_\_\_\_

Any special medical conditions? If so, please describe: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

### 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 listed below is unable to be reached.

Date: \_\_\_\_\_ Consent Signature: \_\_\_\_\_

Client, Parent or Guardian

Print Name: \_\_\_\_\_ 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 located at 2049 – 120<sup>th</sup> Street, Swisher, Iowa. In the event emergency treatment/aid is required, I wish the following procedures to take place, or the following persons to be contacted:

\_\_\_\_\_  
\_\_\_\_\_

Date: \_\_\_\_\_ Non-Consent Signature: \_\_\_\_\_

Client, Parent or Guardian

Print Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_