DREAM CATCHER STABLES INC.

P.O. Box 1454, Spring, TX 77383-1454

Phone: 281-216-3494

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 of the agency, I authorize Dream Catcher Stables Inc. to:

1. Secure and retain medical treatment and transportation if needed.
2. Release my medical information records upon request to the authorized individual or agency involved in the medical emergency treatment.

Participant Name_____ Phone_____

Address_____

In the event I cannot be reached, contact_____ Phone_____

or contact_____ Phone_____

Physician's Name_____ Phone_____

Preferred Medical Facility_____ Phone_____

Health Insurance Co_____ Policy #_____

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 of the agency. In the event emergency treatment/aid is required, I wish the following procedures to take place:

Name_____ Phone_____

_____

_____

_____

_____

Date_____ Non- Consent Signature_____

Client/Volunteer, Parent or Guardian

Print Name_____ Phone_____

Address_____