

DREAM RIDERS

Volunteer Authorization for Emergency Medical Treatment Form

Name _____ DOB _____
 Home Phone _____ Cell Phone _____
 Address _____
 Email: _____
 Physician's Name: _____ Preferred Medical Facility: _____
 Health Insurance Company: _____ Policy #: _____
 Allergies to medications: _____
 Current medications: _____

In the event of an emergency contact:

Name: _____ Relation: _____ Phone: _____
 Name: _____ Relation: _____ Phone: _____
 Name: _____ Relation: _____ Phone: _____

Consent Plan

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 RIDERS 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.

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) above is unable to be reached

Date: _____ Consent Signature: _____

Volunteer, Parent or Legal Guardian if under 18

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 procedure to take place:

Date: _____ Non-Consent Signature: _____

Volunteer, Parent or Legal Guardian if under 18