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 emergency, contact:
Name: ________________________ **Relation:** _________ **Phone:** __________________
Name: ________________________ **Relation:** _________ **Phone** __________________
Name: ________________________ **Relation:** _________ **Phone:** __________________

In the event medical aid/ treatment is required due to illness or injury during the process of volunteering 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 volunteer's records upon request to the authorized individual or agency involved in the medical emergency treatment.

Consent Plan:

This authorization includes x-rays, surgery, hospitalization, medication and any treatment procedure deemed "life saving" by the physician. This provision is only to be invoked if the person(s) above is unable to be reached.
Date: __________________ **Consent Signature:** __________________________________
Volunteer, Parent or Legal Guardian
If under age 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 volunteering or while being on the property of the agency. In the event emergency treatment is required, I wish the following procedures to take place:
____
____
____
____

Date: _______________ **Non Consent Signature:** ________________________________
Volunteer, Parent or Legal Guardian If under age 18

Revised 2013 up date