EMERGENCY RELEASE TREATMENT FORM

GREAAT! Gainesville Riding through Equine Assisted Activities and Therapy

VOLUNTEER'S NAME_____

ADDRESS_____

CITY_____ STATE_____ ZIP_____

PHONE_____

E-MAIL_____

DATE OF BIRTH_____

VOLUNTEERS: ANY DISABILITY THAT MAY AFFECT YOUR ACTIVITIES HERE?
_____

PARENT/GUARDIAN(S) CONTACT INFORMATION (under 21)

_____

PHYSICIAN'S NAME _____PHONE_____

HEALTH INSURANCE COMPANY & POLICY # _____

Person who is authorized to give temporary assistance or care in absence of parent or guardian:

Name _____. Phone_____ Relationship _____

Describe any medical condition requiring precautions or treatment and any medications and dosage:
_____

In case of Emergency, the undersigned authorizes provision of such medical assistance as is determined to be necessary. The undersigned authorizes any licensed physician and/or medical facility to provide any medical/surgical care and/or hospitalization for the volunteer, including anesthetic, which they determine
necessary or advisable.

SIGNATURE_____