EMERGENCY RELEASE TREATMENT FORM

VOLUNTEER'S NAME: _____

PARENT/GUARDIAN (if under 18): _____

PHONE #: (h): _____ (cell): _____

(w): _____ (email): _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

DATE OF BIRTH: _____

PHYSICIAN'S NAME: _____

PHYSICIAN'S ADDRESS: _____

HEALTH CARE PROVIDER: _____

POLICY #: _____

Person authorized to give temporary assistance or care in absence of parent or guardian (if under 18):

NAME: _____

PHONE #: _____ RELATIONSHIP: _____

PERFERRED MEDICAL FACILITY: _____

In case of a Medical Emergency, the undersigned authorizes Willow Farm Therapeutic Riding to provide such medical assistance as they determine to be necessary. The undersigned authorizes any licensed physician and/or medical facility to provide medical surgical care and/or hospitalization for the volunteer, including anesthetic, which they determine to be necessary or advisable, pending receipt of a specific consent from the undersigned.

No volunteer can be accepted until this form has been completed by the parent(s)/guardian if applicable. If the volunteer is of legal age (18), he or she may complete the form. Volunteers will be under supervision and although every effort will be made to avoid any accident, NO LIABILITY can be accepted by Willow Farm Therapeutic Riding.

I would like _____ to volunteer. I understand that NO LIABILITY can be accepted by any organization concerned including WILLOW FARM THERAPEUTIC RIDING in the event of any accident that may occur.

SIGNATURE OF PARENT GUARDIAN: _____

SIGNATURE OF VOLUNTEER (if over 18): _____

DATE: _____