

**Hope Rides Authorization For Medical Treatment**

Office Use Only: \_\_\_\_\_ Date Received: \_\_\_\_\_

**Medical History:**

Student/Volunteer Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
Physician Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
Preferred Medical Facility: \_\_\_\_\_ Phone: \_\_\_\_\_  
Health Insurance Co: \_\_\_\_\_ Policy Number: \_\_\_\_\_

Environmental Allergies / Allergies to Medication:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Current Medications: \_\_\_\_\_

Please list two people who may be contacted in case of emergency:  
Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
Name: \_\_\_\_\_ Phone: \_\_\_\_\_

**Consent To Medical Treatment:**

In the event emergency medical treatment is required due to illness or injury during the process of receiving services, or while being on the property of Shadow Creek Stables, Equine Haven, or any other property while participating in Hope Rides programming and activities, I give permission for Hope Rides to:

1. Secure and retain medical treatment and transportation if needed.
2. Release medical records upon request to the authorized individual or agency involved in the medical emergency treatment
3. Authorize the use of x-ray, surgery, hospitalization, medication and any treatment procedure deemed "life saving" by the physician. **These actions will only be taken if the emergency contacts are unable to be reached.**

I give my consent for emergency medical aid/treatment in the case of illness or injury during the process of receiving service or while being on under the supervision of Hope Rides agency.

Consent Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Volunteer, Parent or Guardian

Non-Consent Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Parent/Guardian

**Non-Consent Plan**

In the event emergency medical treatment is required due to illness or injury during the process of receiving services or while being on the property of Shadow Creek Stable, Equine Haven or any other property while participating in Hope Rides programming and activities, I wish for the

following procedures to take place:

Non-Consent Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Volunteer

Non-Consent Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian

Photo/Testimonials Release

I do consent \_\_\_\_\_ / do not consent \_\_\_\_\_ to and authorize the use of any and all photographs, audiovisuals or verbal testimonials to be used for promotional, educational or exhibition or any other use to benefit Hope Rides Org.

Signature of Release \_\_\_\_\_ Date \_\_\_\_\_

Volunteer, Parent or Guardian

Hope Rides  
12801 Do Little Drive  
Minnetonka MN 55305  
info@hoperides.org