Emergency Medical Release Form

This form is required for participation in Adaptive or Therapeutic horseback riding.

Please complete each section thoroughly, sign and date.

Client's Name: _____ _____
Last First

Sex: F ☐ M ☐ Age: _____ Birthdate (MM/DD/YY): _____

Height:_____ Weight:_____

Ethnicity (For grant purposes) African American___ Asian/Pacific Islander___ Caucasian ___ Hispanic___

Native American ___ Other__

Mother's Name: _____ Home Phone # : (____) _____

Work Phone # : _____ Cell Phone # : (____) _____

Father's Name: _____ Home Phone # : (____) _____

Work Phone # : _____ Cell Phone # : (____) _____

Additional person authorized to pick up my child and/or to contact in case of an illness of an emergency:

Name: _____ Relationship: _____ Phone # : (____) _____

Diagnosis:_____

_____

Allergies – Does your client have any allergies to food, medications, insects, etc.? ☐ Yes ☐ No

If Yes, please list: _____

Health Conditions – Has your client, currently or in the past, been diagnosed with any of the following health conditions (check all that apply):

Asthma	☐ Yes	☐ No	Epilepsy/Seizure Disorder	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Frequent Migraine Headaches	☐ Yes	☐ No
Heart Problems	☐ Yes	☐ No	Attention Deficit-Hyperactivity	☐ Yes	☐ No
Vision/Hearing Problems	☐ Yes	☐ No	Chronic Ear Infections	☐ Yes	☐ No

Does client have Behavioral issues?

If Yes, please explain including triggers:_____

List any other health condition(s) not listed above: _____

List any medication(s) currently taken by client: _____

What goals do you hope to have us help client accomplish?_____

_____

Name of clients Physician: _____

Physician's Phone # : ( ) _____

Name of Insurance Company: _____ Policy # /Medical #: _____

In case of emergency, take my clients to the following hospital (please check one):

☐ Nearest Hospital OR ☐ _____ (name of hospital)

Emergency Release

If, in the judgment of the staff of Bit By Bit the client named above needs immediate care and treatment as a result of any injury or sickness, I do hereby authorize and consent to any x-ray examination, anesthetic, medical, or surgical or dental diagnosis or treatment and hospital care are considered necessary in the best judgment of the attending physician, surgeon or dentist and performed by or under the supervision of the medical staff of the hospital or facility furnishing medical or dental services.

I do hereby agree to indemnify and hold harmless Bit By Bit (including its officers, directors, members and/or volunteers) from any claim by any person whomsoever on account of such care and treatment of said child. It is understood that a good faith attempt shall be made to contact the undersigned prior to rendering treatment to the patient, but that any of the above treatment will not be withheld if the undersigned cannot be reached. Further, it is understood that the undersigned will assume full responsibility for any such action, including payment of costs.

Print Full Name of Parent, Guardian or Client	Signature	Date