Positive PT LLC
541 Jacoby Creek Rd.
Mount Bethel, PA 18343
Positive-PT.com

EMERGENCY TREATMENT RELEASE

Participant: _____Date of birth: _____

Disability & date of onset: _____

Parent/Guardian: _____

Phone(primary)_____(other)_____

Address_____
Street City State ZIP

Physician's name: _____ Telephone:_____

Physician's address: _____

Health insurance provider: _____ Policy #: _____

Preferred medical facility: _____

Emergency contact (other than parent/guardian):

Name: _____ Relationship: _____

Phone(primary)_____(other)_____

Name: _____ Relationship: _____

Phone(primary)_____(other)_____

ALLERGIES:_____

DESCRIBE ANY MEDICAL CONDITIONS REQUIRING PRECAUTIONS/TREATMENT AND ANY MEDICATIONS WITH DOSAGE:

_____
_____
_____

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____ **I GIVE MY CONSENT:** In case of a medical emergency, the undersigned authorizes Positive PT LLC 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 participant, including anesthetic, which they determine to be necessary or advisable, pending receipt of a specific consent from the undersigned.

OR

____ **I DO NOT GIVE MY CONSENT** for emergency medical treatment/aid in the case of illness or injury during the process of receiving services or while being on the property of the agency. In the event emergency treatment/aid is required, I wish the following procedures to take place:

_____
_____
_____

No participant can be accepted for riding until this form has been completed and signed. If the participant is of legal age (18), he or she may complete the form if he/she is legally competent to do so. Riding will be under strict supervision, and although every effort will be made to avoid any accident, NO LIABILITY can be accepted by any of the organizations concerned including Positive PT LLC.

SIGNATURE: _____ **DATE:** _____
(Participant or parent/guardian)