www.4HoovesSMART.com

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EMERGENCY RESPONDERS - IN CASE OF EMERGENCY (I-C-E FORM)

All applicable blanks must be filled-in completely. Print Clearly and Legibly

I/We, ____, am/are the owner(s) or agent(s) of the equine(s) in this trailer being operated by 4HLAS.
Physical Address: ____
Phone: Home (______) __________-____________ Alt (______) __________-____________

Dates of Transport – Pick Up: ______________________________ Drop Off: ______________________________

Emergency Contact (other than Owner/Agent listed above)–
Person(s) with legal authority to make decisions on treatment for the equine(s) and payment for services rendered:
Name: ____
Address: ____
Phone: Home (________) __________-___________ Alt (________) __________-___________

Emergency Transportation Contact –
Person(s) available to pick up and transport the equines from incident or sheltering location if needed (other than 4HLAS):
Name: ____
Address: ____
Phone: Home (________) __________-___________Cell (________) __________-___________

HOLD HARMLESS, VETERINARIAN - In the event that 4HLAS are incapable of communicating and the Owner/Agent is unable to be contacted to make decisions regarding the health and well-being of the equine(s) in an accident or emergency, I, the Owner/Agent hereby authorize and shall hold harmless a licensed veterinarian to determine the condition of the equine(s), provide emergency health care, or administer a euthanizing agent if the licensed veterinarian determines that an equine cannot be saved within the realms of the conditions set forth on the Equine Information form.

LIMITED POWER OF ATTORNEY FOR EQUINE HEALTHCARE made this ____________ day of ________________________, 20______. In the event of an emergency and a member of 4HLAS, the veterinarian on site, or local authorities are unable to contact me/us, the listed successor, or the emergency contact listed on the I-C-E form, I / We, ______________________________(Owner/Agent name), as the owner(s)/agent(s) of equine(s) in the care, custody and control of and transported by 4HLAS, hereby appoint, 4HLAS owners, Justin and Tori McLeod, and/or 4HLAS authorized representatives, as my attorney-in-fact to act for me and in my name in any way I could act in person to make any and all decisions for me concerning the care, medical treatment, hospitalization, and to require, withhold or withdraw any type of medical procedure for my equine(s) listed on the I-C-E form, even though death may ensue within the documented guidelines herein based on the monetary limit for expenses incurred. My attorney-in-fact shall also have full power to make a disposition of any part or all my equine's body for medical purposes, authorize necropsy (equine autopsy) and direct the disposition of my equine's remains.

If the representatives of 4HLAS shall die, become legally disabled, incapacitated or incompetent, or resign, refuse to act, or be unavailable, I name the following successor as an attorney-in-fact for my equine's care and disposition -

SUCCESSOR - Name: ____ Contact Number(s): ____________________________

Physical Address: ____

This power of attorney shall become effective at the time the equine(s) is/are loaded for transport and continue until the equine(s) is/are unloaded at the designated destination or until contact can be made with the owner(s)/agent(s) to relinquish control of the equine's care, management, and disposition.

I'm fully informed as to all contents of this form and understand the full import of this grant of powers to 4HLAS owners and authorized representatives, and the listed successor.

______________________________	______________________________
Owner / Agent Name (Print)	**Owner / Agent Name (Signature)**
______________________________	______________________________
Witness Name (Print)	**Witness Name (Signature)**

____
Witness Physical Address (Street address, City, State, Zip)

____
Witness Phone Number(s)

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Equine #1 Information

Name:	Species: Equine	Age:	Sex:
Breed:	Color:		
Markings:			
Medical History:			
Medications:			
Allergies:	Microchipped (circle one): Yes No		
Maximum Monetary Amount Approved for Emergency Medical Treatment / Expenses: $			
Insurance Company Name:	Contact #:	Policy #:	

Equine #2 Information (if applicable)

Name:	Species: Equine	Age:	Sex:
Breed:	Color:		
Markings:			
Medical History:			
Medications:			
Allergies:	Microchipped (circle one): Yes No		
Maximum Monetary Amount Approved for Emergency Medical Treatment / Expenses: $			
Insurance Company Name:	Contact #:	Policy #:	

Equine #3 Information (if applicable)

Name:	Species: Equine	Age:	Sex:
Breed:	Color:		
Markings:			
Medical History:			
Medications:			
Allergies:	Microchipped (circle one): Yes No		
Maximum Monetary Amount Approved for Emergency Medical Treatment / Expenses: $			
Insurance Company Name:	Contact #:	Policy #:	

Equine #4 Information (if applicable)

Name:	Species: Equine	Age:	Sex:
Breed:	Color:		
Markings:			
Medical History:			
Medications:			
Allergies:	Microchipped (circle one): Yes No		
Maximum Monetary Amount Approved for Emergency Medical Treatment / Expenses: $			
Insurance Company Name:	Contact #:	Policy #:	

 Owner / Agent Initials: ___________________________

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