IN CASE OF EMERGENCY (I-C-E FORM) and LIMITED POWER OF ATTORNEY

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

Date Completed: _____

This form is valid from_____**(beginning date) until**_____**(ending date).**

I/We,_____**, am/are the owner(s) or agent(s) of the equine(s) listed herein.**
Physical Address: _____
Phone: Home (_____)_____-_____ Alt (_____)_____-_____

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 Owner / Agent):
Name: _____
Address:_____
Phone: Home (_____)_____-_____Cell (_____)_____-_____

HOLD HARMLESS, VETERINARIAN - In the event that the person holding Limited Power of Attorney (below) is 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 the person in possession of the equine(s), the veterinarian on site, or local authorities are unable to contact me/us (owner/agent), 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/or transported by _____, hereby appoint,_____, 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 documented 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 owner(s)/agent(s) 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 in the care, custody, and control of _____ _____ and continue until the possession of the equine(s) is/are returned to the owner(s)/agent(s) 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 _____ _____, authorized representatives documented herein, 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)

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: _____