



*Michigan Abilities Center*  
 7286 W. Ellsworth Road, Ann Arbor, MI 48103  
 Phone: (734) MAC-9500 Fax: (734) MAC-9555  
 Website: MichiganAbilitiesCenter.org

**AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT**

Name \_\_\_\_\_ DOB: \_\_\_\_\_ Phone \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_  
 Physician's Name \_\_\_\_\_ Preferred Medical Facility: \_\_\_\_\_  
 Health Insurance Company: \_\_\_\_\_ Policy#: \_\_\_\_\_  
 Allergies to medications or foods: \_\_\_\_\_  
 Current medications: \_\_\_\_\_

In the event of an emergency, contact:

Name \_\_\_\_\_ Relation: \_\_\_\_\_ Phone #1 \_\_\_\_\_ #2 \_\_\_\_\_  
 Name \_\_\_\_\_ Relation: \_\_\_\_\_ Phone #1 \_\_\_\_\_ #2 \_\_\_\_\_  
 Name \_\_\_\_\_ Relation: \_\_\_\_\_ Phone #1 \_\_\_\_\_ #2 \_\_\_\_\_

In the event emergency medical aid/treatment is required due to illness or injury during the process of receiving services, or while being at Heritage Hill, I authorize Michigan Abilities Center and/or Heritage Hill to:

1. Secure and retain medical treatment and transportation if needed.
2. Release client records upon request to the authorized individual or agency involved in the medical emergency treatment.

**Consent Plan**

This authorization includes x-rays, surgery, hospitalization, medication, and any treatment procedure deemed "life saving" by the physician. This provision will only be invoked if the person(s) above is unable to be reached.

Date \_\_\_\_\_ Consent signature \_\_\_\_\_  
 (Rider, Parent or Guardian)

**Non-Consent Plan**

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 or while being at Heritage Hill. My parent, spouse, or legal guardian will remain on site at all times during equine assisted activities and while I am at Heritage Hill. In the event of emergency treatment/aid is required, I wish the following procedure to take place:

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Date \_\_\_\_\_ Non-Consent Signature \_\_\_\_\_  
 (Rider, Parent or Guardian)

A COPY OF THE COMPLETED MEDICAL/HEALTH HISTORY SHOULD BE ATTACHED TO THIS FORM.