HUNKAPI

Hunkapi Horse Programs, AZ

EMERGENCY MEDICAL AUTHORIZATION AND RELEASE FORM

Participant Name: ____ Date of Birth: ____________

Address:____

Parent(s)/Guardian(s)(if applicable): ____

Home Phone:_________________ Cell Phone:___ ___________ Work Phone:______________________

1st Emergency Contact:_______________________________ Phone:______________________________

Relationship to Participant:__________________________________

2nd Emergency Contact:__________________________ _Phone:______________________

Relationship to Participant:___________________________________

Physician Name:_________________________________ Physician Phone:_____________________

Insurance Co:_________________________________ Account #___________________________

IMPORTANT MEDICAL INFORMATION: Please list any facts concerning medical history including allergies, medications being taken, current medical conditions, and any physical impairments or special considerations which should be made known to emergency treatment personnel.

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PLEASE INITIAL <u>EITHER</u> PART I OR PART II and <u>ALL</u> OF PART III

PART I

______ **CONSENT FOR TREATMENT:** I hereby give my consent and authorize the personnel of the Hunkapi Programs Inc. to authorize and arrange for medical treatment, including, but not limited to, x-rays, surgery, anesthesia, hospitalization, medication and any emergency treatment procedures deemed “life saving” by a physician. This provision shall be invoked if I (or my child/ward) am unable to communicate or arrange for treatment, and my parent/guardian or emergency contacts are unable to be contacted in a timely manner. I understand that the cost of any such treatment authorized by Hunkapi Programs Inc. shall remain my responsibility.

PART II

______**NO CONSENT FOR TREATMENT:** I do not give consent for personnel of the Hunkapi Programs Inc. to authorize medical treatment for me (or my child/ward), except to arrange for emergency medical treatment/aid on my behalf. In the event of an emergency, I wish the following to take place:

PART III

_____I agree to indemnify and hold harmless HUNKAPI PROGRAMS INC., and its members, officers, servants, agents, volunteers and employees (hereinafter HUNKAPI PROGRAMS INC.), for any costs incurred to treat me, even if HUNKAPI PROGRAMS INC. has signed medical facility documentation promising to pay for the treatment due to my inability to sign the documentation. I further agree to release, waive, discharge, covenant not to sue, and agree to hold harmless for any and all purposes, HUNKAPI PROGRAMS INC. from any and all liabilities, claims, demands, injuries (including death), or damages, including court costs and attorneys’ fees and expenses, that may be sustained by me while receiving medical care or in HUNKAPI PROGRAMS INC. deciding to seek medical care, including while traveling to and from a medical care facility, including injuries sustained as a result of the sole, joint, or concurrent negligence, negligence per se, statutory fault, or strict liability of HUNKAPI PROGRAMS INC. I understand this waiver does not apply to injuries caused by intentional or grossly negligent conduct.

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Client (over 18 years of age) or Parent/Guardian Signature

Print Name:_______________________________________

Date:___________________