New York State
Horse Health Assurance Program
(NYSHHAP)

OPERATION INFORMATION

Name: THE MOUNTING BLOCK, INC.
Address: 4467 CARTER ROAD FAIRPORT, NY 14450
Contact Person: JULI JAYNE

INDIVIDUAL INFORMATION

PARTICIPANT STAFF VOLUNTEER

Name:_____ DOB:_____ Phone:_____
Address:_____
Physician's Name:_____ Medical Facility:_____
Health Insurance Company:_____ Policy Number:_____
Authorization Telephone Number:_____
Allergies:_____
Current Medication:_____
Current Medical Problems:_____

In the event of an emergency, contact:
Name:_____ Relationship:_____ Phone:_____
Name:_____ Relationship:_____ Phone:_____

In the event emergency medical treatment is required due to illness or injury during the process of receiving services, or while being on the property of the agency, I authorize The Mounting Block, Inc. to:

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

Authorization For Emergency Medical Treatment Cont'd.

CONSENT PLAN

This authorization includes x-ray, 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 contacted.

Consent Signature:_____ Date:_____
Client, parent or legal guardian
Signature witnessed by Premises Staff

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 on the property of the agency. In the event emergency treatment/aid is required, I request the following procedure(s) take place:

Consent Signature:_____ Date:_____