

Hope Reigns Ranch
8019 East McGregor
Rockford, IL 61102
815-262-6008

**Volunteer's Authorization For
Emergency Medical Treatment Form**

In the event emergency medical aid/treatment is required due to illness or injury during the process of volunteering their services, or while being on the property of the organization. I authorize Hope Reigns Ranch to secure and retain medical treatment and transportation if needed.

Volunteer's Name: _____ Phone: _____

Address: _____

In the event I cannot be reached, contact: _____ Phone: _____

Physician's Name: _____

Preferred Medical Facility: _____

Health Insurance Co: _____ Policy #: _____

Consent Plan

This authorization includes x-ray, surgery, hospitalization, medication and any treatment procedure deemed "life saving" by the physician.

Date: _____ Consent Signature: _____

(Volunteer, Parent or Guardian)

Print Name: _____ Phone: _____

Address: _____

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 wish the following procedures to take place:

Date _____ Non-Consent Signature _____

(Volunteer, Parent or Guardian)

Name (Print): _____ Phone: _____

Address: _____