Hope Reigns Ranch
5201 Safford Rd.
Rockford, IL 61102
815-299-4673

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: