



Therapeutic Riding Center
Westfield NY.

VOLUNTEER EMERGENCY TREATMENT RELEASE FORM

Name: _____ Phone: (H) _____ (W) _____

Address: _____

City _____ State _____ Zip _____

Physician's Name _____ Phone _____

Address _____

City _____ State _____ Zip _____

Medical Insurance Co. _____

Co. or Agent phone # _____

Social Security Number _____

Company Address _____

City _____ State _____ Zip _____

In the event of an emergency

Please notify _____ Phone _____

Address _____

City _____ State _____ Zip _____

Relationship _____

I, the undersigned, do hereby give and grant consent and authorization to the Centaur Stride riding instructor to obtain and have rendered medical aid, treatment, or care to the above named Centaur Stride volunteer in the event of medical necessity.

Signature _____ Date _____

(Volunteer/staff)

Signature _____ Date _____

(If under age 18, Parent/ Guardian co-sign)