

Sebastian Riding Associates, Inc.

Therapeutic & Educational Riding Programs for Children & Adults with Disabilities
3589 B Water Street ♦ Collegeville, PA 19426 ♦ 610-489-3741 ♦ www.sebastianriding.org



EMERGENCY TREATMENT

Student: _____ Date of Birth: _____

Parent, Spouse or Guardian: _____

Address: _____
(Street Address, City, State, Zip)

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Physician: _____ Phone: _____

Address: _____

Health Insurance Company: _____ Policy No. _____

Preferred Medical Facility: _____

Individual Authorized to give temporary assistance or care in the absence of parent or guardian.

Name: _____ Relationship: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Are there any medical conditions requiring special precautions or treatment and medications and dosage?

No Yes (please describe)

In case of a Medical Emergency, the undersigned authorizes Sebastian Riding Associates to provide such medical assistance as they deem necessary.

The undersigned authorizes any licensed physician and/or medical facility to provide any medical/surgical care and/or hospitalization for the student, including anesthetic, which they determine necessary or advisable, pending receipt of a specific consent from the undersigned.

✓ Signed: _____ Date: _____
Client/Parent/Guardian