Therapeutic Riding / Hippotherapy Program
McFadden Ranch 2480 Lane 30 1/2
P.O. Box 151 Ω Greybull, WY 82426 Ω Cindy Hinckley: 765-4773 Ω Sandy McFadden: 765-9684

AUTHORIZATION TO TREAT A MINOR

I (we) the undersigned parents, parents or legal guardian of _____, a minor, do hereby authorize and consent to any X-ray examination, anesthetic, medical or surgical diagnosis rendered under the general or special supervision of any member of medical staff and emergency room staff. It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care being required, but is given to provide authority and power to render care which the aforementioned physician in the exercise of his best judgement may deem advisable. It is understood that every effort shall be made to contact the undersigned prior to rendering treatment to the patient, but that treatment will not be withheld if the undersigned cannot be reached.

List any restrictions:
_____
_____
_____
_____

Signature of Parent or Legal Guardian Date

Address City State Zip

This consent shall remain effective until _____, 200___.

Birth Date _____Date of Last Tetanus/Toxoid Booster _____

Current Diagnosis _____

Allergies to Medications or Foods _____

Medications or Other Pertinent Information _____

In case of an emergency, please list phone of:

Parent: Guardian: Other: