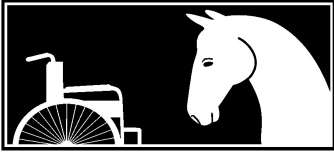


WE CAN RIDE



P.O. Box 1102
MINNETONKA, MN 55345
(952) 934-0057
FAX: (952) 974-9688
WWW.WECANRIDE.ORG

2012 AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

Client's Name: _____	Phone: _____	OFFICE USE
Address: _____	City, State, Zip: _____	<i>I</i> _____
Physician's Name: _____		<i>day/time</i> _____
Preferred Medical Facility: _____		<i>II</i> _____
Health Insurance Co.: _____	Policy #: _____	<i>day/time</i> _____
Allergies to medications: _____		<i>III</i> _____
Current medications: _____		<i>day/time</i> _____
		<i>IV</i> _____
Please list two people who may be contacted in case of emergency (these may include guardian)		<i>day/time</i> _____
Name: _____	Relation: _____	Phone: _____
		<i>V</i> _____
Name: _____	Relation: _____	Phone: _____
		<i>day/time</i> _____

In the event emergency medical aid/treatment is required due to illness or injury during the process of receiving services or while being on the property of the agency, I authorize *We Can Ride, Inc.* to:

1. Secure and retain medical treatment and transportation if needed.
2. Release client records upon request to the authorized individual or agency involved in the medical emergency treatment.
3. To take all other reasonable measures to secure medical aid for the emergency.

Consent Plan

This authorization includes x-ray, surgery, hospitalization medication and any treatment procedure deemed "life saving" by the physician. This provision will only be invoked if the person(s) above is unable to be reached.

Signature X _____ Date _____
Client, Parent or Guardian

Photo Release

CHECK ONE: I hereby (**do consent** / **do not consent**) to and authorize the use and public distribution of any and all photographs of myself or others for whom I am authorized to give consent, including the use of audio/visual materials for promotion, education or exhibition or any other use to benefit *We Can Ride, Inc.*

Signature of Release X _____ Date _____
Client, Parent or Guardian