

**New York State  
Horse Health Assurance Program  
(NYSHHAP)**

**OPERATION INFORMATION**

**Name: THE MOUNTING BLOCK, INC.**  
Address: 4467 CARTER ROAD FAIRPORT, NY 14450  
Contact Person: JULI JAYNE

**INDIVIDUAL INFORMATION**

PARTICIPANT

STAFF

VOLUNTEER

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Phone: \_\_\_\_\_  
Address: \_\_\_\_\_  
Physician's Name: \_\_\_\_\_ Medical Facility: \_\_\_\_\_  
Health Insurance Company: \_\_\_\_\_ Policy Number: \_\_\_\_\_  
Authorization Telephone Number: \_\_\_\_\_  
Allergies: \_\_\_\_\_  
Current Medication: \_\_\_\_\_  
Current Medical Problems: \_\_\_\_\_

In the event of an emergency, contact:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_  
Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

In the event emergency medical 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 The Mounting Block, Inc. to:

- Secure and retain medical treatment and transportation if needed.
- Release client records upon request to the authorized individual or agency involved in the medical emergency treatment room.

Authorization For Emergency Medical Treatment Cont'd.

**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 contacted.

Consent Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Client, parent or legal guardian

Signature witnessed by Premises Staff

**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 request the following procedure(s) take place:

Consent Signature: \_\_\_\_\_ Date: \_\_\_\_\_