

**EMERGENCY INFORMATION AND RELEASE**

Name of Client: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

School presently attending/Employer: \_\_\_\_\_

Caregivers' Names: \_\_\_\_\_

Address if different: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

In case of medical emergency, contact:

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

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

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

**Client Medical Summary:**

Primary Diagnosis: \_\_\_\_\_ Cause: \_\_\_\_\_

Other diagnoses: \_\_\_\_\_

Brief current medical condition (include any recent surgeries, medical changes, etc.)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Current Medications:**

Name: \_\_\_\_\_ Dose: \_\_\_\_\_ For treatment of: \_\_\_\_\_

Name: \_\_\_\_\_ Dose: \_\_\_\_\_ For treatment of: \_\_\_\_\_

Name: \_\_\_\_\_ Dose: \_\_\_\_\_ For treatment of: \_\_\_\_\_

Name: \_\_\_\_\_ Dose: \_\_\_\_\_ For treatment of: \_\_\_\_\_

Allergies \_\_\_\_\_

Preferred medical facility: \_\_\_\_\_

Physician's Name: \_\_\_\_\_

Health Insurance Company: \_\_\_\_\_

Policy Holder's Name: \_\_\_\_\_ Policy #: \_\_\_\_\_

**Authorization for Emergency Medical Treatment:**

In the event that emergency medical aid/treatment is required due to illness or injury during the process of receiving services or being on the property of Palermo Show Stable, I authorize Palermo Show Stable to:

1. Secure and retain medical treatment and transportation as needed, and
2. Release client medical and treatment records upon request to the authorized individual or agency involved in the medical emergency care of the client.
3. This authorization includes X-ray, surgery, hospitalization, medication and any treatment procedure deemed "life saving" by the attending physician (This provision will only be invoked if the person(s) listed above is/are unable to be reached).

To my knowledge, the information I have given on this form is complete and accurate.

Print full name: \_\_\_\_\_

Caregiver/Client/Legal Guardian consent signature: \_\_\_\_\_

Date: \_\_\_\_\_