

**AUTHORIZATION FOR  
EMERGENCY MEDICAL TREATMENT**

Date \_\_\_\_\_

Participant's name \_\_\_\_\_

In case of emergency, contact:

1) Name \_\_\_\_\_ Relationship \_\_\_\_\_

Phone (home) \_\_\_\_\_ (work) \_\_\_\_\_ (cell) \_\_\_\_\_

2) Name \_\_\_\_\_ Relationship \_\_\_\_\_

Phone (home) \_\_\_\_\_ (work) \_\_\_\_\_ (cell) \_\_\_\_\_

Please sign ONE of the following two options:

1) Consent Option

In the event emergency medical aid/treatment is required due to illness or injury while participating in an AOR program or while on the property of Acres of Opportunity Ranch (AOR), I authorize AOR to secure and retain medical treatment and transportation if needed. This authorization includes, but is not limited to x-ray, surgery, hospitalization, medication and any treatment deemed "life-saving" by the physician. This provision will be invoked only if the emergency contact person(s) listed above is/are unable to be reached. The financial charges will be paid by the ill/injured person.

Physician's name \_\_\_\_\_ Phone number \_\_\_\_\_

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

Health insurance company \_\_\_\_\_ Policy # \_\_\_\_\_

\_\_\_\_\_  
*Signature of participant or parent/guardian if participant is under age 18*

2) Non-Consent Option

I do not give my consent for emergency medical treatment in the case of illness or injury while participating in an AOR program or while on the property of AOR.

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

\_\_\_\_\_  
*Signature of participant or parent/guardian if participant is under age 18*