TREATMENT AUTHORIZATION FORM

No Frills April 21st and 22nd, 2017

I, the undersigned, am the owner/agent authorized to give permission for medical care and to guarantee payment for such on behalf of the below named horse that is competing in the following ride(s).

Check one or more of the following on April 21st and 22nd, 2017:

____ NF 30 Mile Ride (4/21/17) ____ NF 50 Mile Ride (4/21/17)

____ NF30 Mile Ride (4/22/17) ____ NF 50 Mile Ride (4/22/17)

I understand that if this horse is pulled at any point in the ride or stops because of a rider option, I am required to allow the Endurance Treatment Vet (ETV) to perform a courtesy (no charge) metabolic/lameness safety check on the horse upon arrival back to base camp. At such time, if treatment is recommended for any condition, the ETV will discuss all options and costs with me. I understand that my consent for treatment is considered a guarantee that I will pay for such treatment.

If this horse has been presented to the ETV for evaluation, and the ETV deems it necessary that this horse receive treatment, and in the event that I cannot be reached after attempts have been made to contact me, I choose the following (circle and initial choice A or B):

A. I do not authorize any diagnostics/treatment to be given to stabilize this horse's medical condition. I understand that if I choose this option, I also give the ETV permission to consult with at least two other equine veterinarians. If, in the majority opinion of those veterinarians, this horse's condition is determined to be life threatening without diagnostics/treatment, I hereby give permission for this horse to be humanely destroyed to prevent further suffering and will pay for that procedure.

B. I do authorize and guarantee payment for any diagnostics/treatment to be given to stabilize this horse's medical condition. If the ETV recommends that referral to an equine hospital/clinic for further evaluation and treatment is in the best interest of this horse, I choose either option 1, 2, or 3 below: (circle and initial a choice)
    1. I do not want this horse to be referred to an equine hospital/clinic.
    2. I do want this horse to be referred to an equine hospital/clinic, but ***only*** for a life threatening condition.
    3. I do want this horse to be referred to an equine hospital/clinic for ***any*** condition (either career ending or life threatening condition).

    If I have given permission for referral, this form will be sent with this horse and will serve as permission for the referral hospital/clinic to treat this horse and to guarantee payment for such treatment.

Owner/authorized agent name (printed): _____

Address _____

Phone, cell _____ Phone, home _____

Email address _____

Horse's full name _____ Nickname _____

Age _____ Color _____ Sex _____ Breed_____

Insurance contact info if horse is insured _____

List any known medication allergies_____

Owner/authorized agent signature _____ Date _____

PLEASE NOTE: No horse can start either of the above listed rides unless this form has been filled out, signed, and returned to the ride secretary.

HORSE NUMBER: _____ (to be filled in by ride secretary)