dynamic strides THERAPY

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT
EMERGENCY MEDICAL RELEASE FORM.

Covered Person's Name: _____ DOB: _____ AGE: _____

Covered Person is a: ____ DST Volunteer or ____ DST Patient (Check One)

Should a medical emergency arise, I understand reasonable efforts will be made to contact me prior to rendering treatment to the Covered Person, but that treatment will not be withheld if I cannot be reached.

I give my permission to Dynamic Strides Therapy, Inc. ("DST"), staff, employees, or designees to render first aid to the Covered Person should the need arise or to take the Covered Person to the emergency room of the nearest hospital. I hereby authorize the hospital's medical staff to provide treatment which a physician deems necessary for the well-being of the Covered Person. It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care being required, but is given to provide authority and power to render care which the aforementioned physician, in the exercise of his/her best judgment, may deem advisable. I understand that it is my responsibility for the payment of any and all expenses connected with the injury and/or illness that may not by covered by my insurance.

RELEASE AND HOLD HARMLESS: (A) Covered Person, for himself/herself; or (B) Parent(s)/Legal Guardians(s), on behalf of themselves the Covered Person, and, in the case of both (A) and (B), each of their respective heirs, further agree to and do hereby release and hold harmless Dynamic Strides Therapy, Inc. and its officers, directors, associates, employees, and agents from and against any and all liability, claims, damages, demands, causes of action, and judgments, including but not limited to those relating to personal injury and damage to or loss of property, (collectively "Claims") that arise from or relate to the administration of emergency medical services to the Covered Person. This release and hold harmless applies to claims on tort, negligence (including the negligence of Dynamic Strides Therapy, Inc.), privacy interests, and otherwise whether now known or that may arise in the future. This release and hold harmless does not apply to claims based on action or inaction by those otherwise released and held harmless that constitutes gross negligence or an intentional tort.

Furthermore, I agree to indemnify Dynamic Strides Therapy, Inc. and its officers, directors, associates, employees, and agents from any suit, claim or action brought by the Covered Person, the Covered Person's other parent and/or legal guardian (if any), and any other person related to the Covered Person in connection with this matter.

A copy of this consent shall serve the same purposes and have the same force, effect and authority as an original. I declare that I have completely read and fully understand the information contained in this authorization form and voluntarily accept the terms and conditions. By my signature below, I declare that I am the Covered Person or the parent/legal guardian of the Covered Person authorized to sign this form and give permission for emergency medical treatment on behalf of the Covered Person.

2673 E Sawyer Road • Republic, MO • 65738
Phone: 417-324-7646
Fax: 417-627-5542

Covered Person (Signature): _____ Date: _____

If Covered Person is a minor, Parent/Legal guardian Name (Print) _____

If Covered Person is a minor, Parent/Legal guardian (Signature): _____ Date: _____

Signatory's Home Phone Number: _____ Cell: _____

Signatory's Home Address: _____

City State Zip

2673 E Sawyer Road • Republic, MO • 65738
Phone: 417-324-7646

Fax: 417-627-5542