

# EMERGENCY RESPONDERS - IN CASE OF EMERGENCY

## ANIMALS TRANSPORTED BY OWNER / AGENT FOR OWNER

\*Make two copies - Put completed forms in separate sealed envelopes, each labeled I.C.E. in large letters – Using tape, secure one envelope to the dash, front window or other highly visible area of the towing vehicle and one on the inside of a rear trailer window for access by emergency responders\*

### \*\*\*\*\*VEHICLE OCCUPANT INFORMATION\*\*\*\*\*

Departure Date: \_\_\_\_\_ Scheduled Arrival Date: \_\_\_\_\_

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

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

Vehicle Occupants (document additional occupant's information on the reverse side) –

#1) Name: \_\_\_\_\_

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

Phone: Home (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Alt (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

DOB: \_\_\_\_\_ Blood Type: \_\_\_\_\_ Allergies: \_\_\_\_\_

Medical Insurance Company: \_\_\_\_\_

Medical History: \_\_\_\_\_

Medications: \_\_\_\_\_

Surgeries: \_\_\_\_\_

#2) Name: \_\_\_\_\_

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

Phone: Home (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Alt (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

DOB: \_\_\_\_\_ Blood Type: \_\_\_\_\_ Allergies: \_\_\_\_\_

Medical Insurance Company: \_\_\_\_\_

Medical History: \_\_\_\_\_

Medications: \_\_\_\_\_

Surgeries: \_\_\_\_\_

Emergency Contacts–

#1) Name: \_\_\_\_\_

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

Phone: Home (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Alt (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Name: \_\_\_\_\_

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

Phone: Home (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Alt (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

#2) Name: \_\_\_\_\_

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

Phone: Home (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Alt (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Name: \_\_\_\_\_

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

Phone: Home (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Alt (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Physician / Primary Health Care Provider:

#1) Name: \_\_\_\_\_

Clinic: \_\_\_\_\_ City/State: \_\_\_\_\_

Phone: Office (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Alt (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

#2) Name: \_\_\_\_\_

Clinic: \_\_\_\_\_ City/State: \_\_\_\_\_

Phone: Office (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Alt (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

\*\*\*\*\*OWNER/AGENT, ANIMAL, AND EMERGENCY CONTACT INFORMATION\*\*\*\*\*

I/We, \_\_\_\_\_, own, or are the agent(s) for the owner(s), of the animal(s) in this vehicle and/or trailer.

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

Phone: Home (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Alt (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Departing Location: \_\_\_\_\_

Destination Location: \_\_\_\_\_

**Emergency Contact-**

Person(s) with legal authority to make decisions on treatment for the animal(s) and payment for services rendered:

Name: \_\_\_\_\_

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

Phone: Home (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Alt (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

E-mail: \_\_\_\_\_

Name: \_\_\_\_\_

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

Phone: Home (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Alt (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

E-mail: \_\_\_\_\_

**Veterinarian(s):**

Name: \_\_\_\_\_

Clinic: \_\_\_\_\_ City/State: \_\_\_\_\_

Phone: Office (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Cell (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Emergency Contact (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

E-mail: \_\_\_\_\_

Name: \_\_\_\_\_

Clinic: \_\_\_\_\_ City/State: \_\_\_\_\_

Phone: Office (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Cell (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Emergency Contact (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

E-mail: \_\_\_\_\_

**Transportation Contact -**

Person(s) available to pick up and transport the animals from incident or sheltering location:

Name: \_\_\_\_\_

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

Phone: Home (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Cell (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

E-mail: \_\_\_\_\_

Name: \_\_\_\_\_

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

Phone: Home (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Cell (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

E-mail: \_\_\_\_\_

In the event that I/we are incapacitated or incapable of making decisions regarding the health and well-being of the animal(s) in an accident or emergency, we hereby authorize and shall hold harmless a licensed veterinarian to determine the health status of the animal(s), provide emergency health care, or administer a euthanizing agent if the veterinarian determines that an animal cannot be saved within the monetary parameter documented herein.

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
\_\_\_\_\_

*Owner / Agent Name, Signature and Date*

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
\_\_\_\_\_

*Witness Name, Signature and Date*

\*\*\*\*\*Animal Information (All Animals in Vehicle and Trailer – Horses, Cows, Llamas, Dogs, Cats, Reptiles, etc.)\*\*\*\*\*

<b>Name:</b>	<b>Registered Name:</b>		<b>Species:</b>	
<b>Breed:</b>	<b>Color:</b>	<b>Sex:</b>	<b>Age:</b>	
<b>Markings:</b>				
<b>Medical History:</b>				
<b>Medications:</b>				
<b>Allergies:</b>		<b>Microchipped (circle one):</b> Yes No		
<b>Maximum Monetary Value Authorized for Medical Treatment / Expenses: \$</b>		<b>Monetary Value of Animal: \$</b>		
<b>Insurance Company Name:</b>		<b>Contact #:</b>	<b>Policy #:</b>	

<b>Name:</b>	<b>Registered Name:</b>		<b>Species:</b>	
<b>Breed:</b>	<b>Color:</b>	<b>Sex:</b>	<b>Age:</b>	
<b>Markings:</b>				
<b>Medical History:</b>				
<b>Medications:</b>				
<b>Allergies:</b>		<b>Microchipped (circle one):</b> Yes No		
<b>Maximum Monetary Value Authorized for Medical Treatment / Expenses: \$</b>		<b>Monetary Value of Animal: \$</b>		
<b>Insurance Company Name:</b>		<b>Contact #:</b>	<b>Policy #:</b>	

<b>Name:</b>	<b>Registered Name:</b>		<b>Species:</b>	
<b>Breed:</b>	<b>Color:</b>	<b>Sex:</b>	<b>Age:</b>	
<b>Markings:</b>				
<b>Medical History:</b>				
<b>Medications:</b>				
<b>Allergies:</b>		<b>Microchipped (circle one):</b> Yes No		
<b>Maximum Monetary Value Authorized for Medical Treatment / Expenses: \$</b>		<b>Monetary Value of Animal: \$</b>		
<b>Insurance Company Name:</b>		<b>Contact #:</b>	<b>Policy #:</b>	

<b>Name:</b>	<b>Registered Name:</b>		<b>Species:</b>	
<b>Breed:</b>	<b>Color:</b>	<b>Sex:</b>	<b>Age:</b>	
<b>Markings:</b>				
<b>Medical History:</b>				
<b>Medications:</b>				
<b>Allergies:</b>		<b>Microchipped (circle one):</b> Yes No		
<b>Maximum Monetary Value Authorized for Medical Treatment / Expenses: \$</b>		<b>Monetary Value of Animal: \$</b>		
<b>Insurance Company Name:</b>		<b>Contact #:</b>	<b>Policy #:</b>	

<b>Name:</b>	<b>Registered Name:</b>		<b>Species:</b>	
<b>Breed:</b>	<b>Color:</b>	<b>Sex:</b>	<b>Age:</b>	
<b>Markings:</b>				
<b>Medical History:</b>				
<b>Medications:</b>				
<b>Allergies:</b>		<b>Microchipped (circle one):</b> Yes No		
<b>Maximum Monetary Value Authorized for Medical Treatment / Expenses: \$</b>		<b>Monetary Value of Animal: \$</b>		
<b>Insurance Company Name:</b>		<b>Contact #:</b>	<b>Policy #:</b>	

<b>Name:</b>	<b>Registered Name:</b>		<b>Species:</b>	
<b>Breed:</b>	<b>Color:</b>	<b>Sex:</b>	<b>Age:</b>	
<b>Markings:</b>				
<b>Medical History:</b>				
<b>Medications:</b>				
<b>Allergies:</b>		<b>Microchipped (circle one):</b> Yes No		
<b>Maximum Monetary Value Authorized for Medical Treatment / Expenses: \$</b>		<b>Monetary Value of Animal: \$</b>		
<b>Insurance Company Name:</b>		<b>Contact #:</b>	<b>Policy #:</b>	

\*\*\*\*\*LIMITED POWER OF ATTORNEY FOR ANIMAL HEALTHCARE\*\*\*\*\*

Limited power of attorney made this \_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_. I/We, (name) \_\_\_\_\_, of (address) \_\_\_\_\_, (city) \_\_\_\_\_, (state) \_\_\_\_\_, (zip code) \_\_\_\_\_, hereby appoint: my (relationship) \_\_\_\_\_ (appointee name) \_\_\_\_\_

as my attorney-in-fact (my "agent") to act for me and in my name in any way I could act in person to make any and all decisions for me concerning the care, medical treatment, hospitalization, and to require, withhold or withdraw any type of medical procedure for my animal(s), even though death may ensue. My agent shall also have full power to make a disposition of any part or all of my animal's body for medical purposes, authorize autopsy and direct the disposition of my animal's remains.

This power of attorney shall become effective on (start date) \_\_\_\_/\_\_\_\_/\_\_\_\_ and continue until: (check one)  (end date) \_\_\_\_/\_\_\_\_/\_\_\_\_, or  until further notice.

If any agent named by me as an "Emergency Contact" as documented on the "In Case of Emergency" form, shall die, become legally disabled, incapacitated or incompetent, or resign, refuse to act, or be unavailable, I name the following:

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone Number(s): \_\_\_\_\_  
Email: \_\_\_\_\_

I'm fully informed as to all contents of this form and understand the full import of this grant of powers to my agent.

Owner(s) / Agent(s) Signature(s) \_\_\_\_\_ Owner(s) / Agent(s) Print Name(s) \_\_\_\_\_

The owner(s) / agent(s) has had an opportunity to read the above form and has signed the above in my presence. I, the undersigned, being over eighteen years of age, hereby witness the owner(s) / agent(s) signature at the request and in the presence of the owner(s) / agent(s), and in the presence of each other; the day and year above set out.

Witness Signature \_\_\_\_\_ Print Name \_\_\_\_\_

Print Physical Address \_\_\_\_\_

**4HFES AND NC SMART, LLC**  
NOTARY RECOMMENDED  
4HOOVES FARM EQUINE SERVICES  
NORTH CAROLINA SPECIALIZED MOBILE ANIMAL RESCUE TEAM

Notary Signature \_\_\_\_\_ Print Name \_\_\_\_\_

The foregoing instrument was acknowledged before me this \_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_, by (name) \_\_\_\_\_ - Notary Public/Justice of the Peace.  
My commission expires: \_\_\_\_/\_\_\_\_/\_\_\_\_

*The purpose of this document is to give the person you designate (Your "Agent") broad powers to make health care decisions for your animal(s), including power to require, consent to or withdraw any type of care or medical treatment for any medical condition and to admit or discharge your animal(s) from any hospital, clinic or other institution. This document does not impose a duty on your agent to exercise granted powers; but when a power is exercised, your agent will have to use due care to act for your benefit and in accordance with this form. A court can take away the powers of your agent if it finds the agent is not acting properly. You may name co-agents and successor agents under this form, but you may not name a health care provider who may be directly or indirectly involved in rendering health care to your animal(s) under this power. Unless you expressly limit the duration of this power in the manner provided below, until you revoke this power or a court acting on your behalf terminates it, your agent may exercise the powers given herein throughout your lifetime even after you become disabled, incapacitated or incompetent. It is recommended that you keep a copy of this document in your tow vehicle and trailer, along with a copy of the "Emergency Responders – In Case of Emergency" document, which provides additional contact information and details on the care and treatment of the animals. If there is anything about this form that you do not understand, you should consult a lawyer.*