



RIDE YOUR HORSE! Therapeutic Riding Program

VOLUNTEER / STAFF INFORMATION AND HEALTH HISTORY

Volunteer/Staff Name: _____ DOB: ____/____/____ Age: _____ Gender: M F

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: (____) _____ Work # (____) _____ Cell # (____) _____
*(Please indicate * which number is best to reach you approximately 2 hours prior to lesson time.)*

E-mail _____ Employer/School: _____

Parent/ Legal Guardian
Names: _____

Address: (if different from above) _____
City: _____ State: _____ Zip: _____ Home Phone: (____) _____

Emergency
Contact: _____ Phone: (____) _____

Emergency
Contact: _____ Phone: (____) _____

How did you hear about us? (please check one) Friend/Relative Phone Book Internet Flyer
 Magazine (which one) _____ Newspaper (which one) _____
Are you related to any of our Participants? If so, Whom? _____

Do you have CPR or First Aid Training? CPR Adult Expires _____ CPR Child Expires _____
 First Aid Expires _____

CHECK ALL AREAS/TASKS/SKILLS YOU ARE INTERESTED IN:

Program Volunteer

- Leading a Horse
- Side Walking w/ a student
- Arena Crew
- Tack Cleaning

Administration

- Office Work/Packets/Scheduling
- Newsletters
- Scrapbook
- Photography/Videography

Program Maintenance

- Painting
- Carpentry /Repairs
- Gardening
- Stall Duty

Special Skills: (Horse Experience and or Experience with or relations to Persons with Disabilities) _____

Please Check the Days You Are Available (NOTE: Tuesdays are “make up” days for students and volunteer requirements for Tuesday will vary by week):

To Volunteer Each Week: Monday Tuesday Wednesday Thursday Friday
 On Call for Volunteering: Monday Tuesday Wednesday Thursday Friday
 On Call for Special Events: Saturday Sunday

Lessons are typically scheduled between 11:00 am and 6:15 pm. See online lesson schedule for specifics.



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HEALTH HISTORY

A therapeutic riding program can be physically and emotionally demanding. Handling of tack, equipment, grooming and assisting in the mounting/dismounting of participants may involve heavy lifting, reliance upon physical strength and emotional support. In addition, volunteers/staff may be required to walk and or jog in sand/loose soil alongside horses and or stand for extended periods of time. We strive to match our volunteers/ staff with the appropriate participants, horses and tasks to maximize the safety and benefits of our program. Please provide us with the following health information:

Height: _____ Weight: _____ Maximum Weight you can lift: _____
(example: 20 lb pet food)

Any restrictions (please check all that apply):

Lifting Running Walking Standing Other _____

Please explain restrictions and describe your current health status, particularly regarding the physical/emotional demands of working in a therapeutic riding program. Address fitness, cardiac, respiratory, bone, or joint function, recent hospitalizations/surgeries or lifestyle changes:

Date of last Tetanus shot: _____ Date of most recent Tuberculosis test: _____ Result? + --
Allergies (to Medications, etc.): _____ Medications: _____

PHOTO RELEASE:

I DO
 DO NOT

Consent to and authorize the use and reproduction by RIDE YOUR HORSE! THERAPEUTIC RIDING PROGRAM of any and all photographs and any other audio/visual materials taken of me for promotional material, educational activities, exhibitions or for any other use for the benefit of the center.

Signature: _____ Date: _____

BACKGROUND INFORMATION:

DRIVER'S LICENSE NUMBER: _____ STATE: _____

Have you ever been charged with or convicted of a crime? Y N Please explain _____

I, _____ (volunteer/staff), authorize Ride Your Horse! Therapeutic Riding Program to receive information from any law enforcement agency, including police departments and sheriff's departments, of this state or any other state or federal government, to the extent permitted by state and federal law, pertaining to any convictions I may have had for violations of state or federal criminal laws, including but not limited to convictions for crimes committed upon children or animals.

I understand that such access is for the purpose of considering my applications as an employee/volunteer, and that I expressly DO NOT authorize Ride Your Horse! Therapeutic Riding Program, its directors, officers, employees, or other volunteers to disseminate this information in any way to any other individual, group, agency, organization, or corporation.

Signature: _____ Date: _____



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Authorization for Emergency / Medical Treatment Form

CHECK ONE: CLIENT VOLUNTEER STAFF

Rider's Name: _____ DOB: _____ Phone: (____) _____
Address: _____

Physician's Name: _____ Phone: (____) _____
Health Insurance Co: _____ Policy # _____
Preferred Medical Facility: _____ Address: _____

Emergency Contacts:

In the event I cannot be reached, Contact: _____ Relationship: _____
Phone: (____) _____ Alt #: (____) _____

Contact: _____ Relationship: _____
Phone: (____) _____ Alt#: (____) _____

Allergies to Medications: _____
Current Medications: _____

In the event emergency medical aid/ treatment is required due to illness or injury during the process of receiving services, volunteering, or while being on the property of the agency, I authorize **Ride Your Horse! Therapeutic Riding Program** to:

1. Secure and retain medical treatment and transportation if needed.
 2. Release participate or volunteer records upon request to the authorized individual or agency involved in the medical emergency
- That I further understand that should medical emergency treatment be required, the current insurance information here listed will be providing to the attending clinic or hospital to cover future payment of incurred bills.

(Initials)

I/WE AGREE THAT: Should medical treatment be required, I and/or my medical insurance carrier shall pay for ALL such incurred expenses.

Consent Plan:

(Initials)

This authorization includes x-ray, surgery, hospitalization, medication and any treatment procedure deemed "life saving" by the physician. This provision will only be invoked if the contacts listed above are unable to be reached.

Date: _____ Consent Signature: _____

(Rider, Parent or Guardian)

Print Name: _____ Phone: (____) _____
Address: _____ City: _____ State: _____ Zip: _____

Non-Consent Plan:

I do not give my consent for emergency medical treatment/ aid in the case of illness or injury during the process of receiving services, volunteering, or while being on the property of the agency. In the event emergency treatment/ aid is required, I wish the following procedures to take place (If you choose this plan, you must fill in some specifics for the aid which you will/will not allow):

***Parent or legal guardian will remain on site at all times during equine assisted activities.**

(Initials)

Date: _____
Consent Signature: _____

(Rider, Parent, or Guardian)

Print Name: _____ Phone: (____) _____
Address: _____ City: _____ State: _____ Zip: _____



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VOLUNTEER/STAFF LIABILITY RELEASE

In consideration of my/my child's/my ward's participation in any equine or other day camp or volunteer-related activities at Ride Your Horse! Therapeutic Riding Program, hereafter know as Ride Your Horse!, I hereby release and waive my rights to sue Ride Your Horse!, its staff and the owner of the property, for any loss, damage, injury or death to persons or property sustained by me/my child/my ward in equine or other activities by any cause whatsoever including risks inherent in equine or other activities, such as but not limited to:

1. The propensity for equines to behave in dangerous ways which may result in injury or death to participants or bystander, or damage to property.
2. The inability to predict an equine's reactions to sound, movements, objects, persons, or animals.
3. The hazards of surface or subsurface conditions, whether known or unknown of the farm, arena, playground, or barn environment.

I assume all of the foregoing risks inherent in equine and other activities and accept complete responsibility relating to those risks and any other potential risks of recreational, horse show, camp, maintenance, or volunteer activities. I am in sufficient physical/mental condition to perform the functions asked of a volunteer/staff member at Ride Your Horse!. I hereby, intending to be legally bond for myself, my heirs, and assigns, executors or administrators, waive and release forever all claims for damages against Ride Your Horse!, its staff and the owner of the property, from and against, any and all loss, damage, injury, or death, to person or property, by whatever cause, including any act of omission. I agree to indemnify Ride Your Horse! and the owners of stable property against all claims, demands, suites, and expenses arising out of any injury to any person or damage to any property caused by animals, attendants, or myself/my children/my wards. This waiver shall be valid until expressly revoked in writing by myself or a legally appointed guardian. (Parents/legal guardians must sign for children under 18 or wards of the court. Both parents/guardians must sign below if there is joint or shared custody.)

Signature: _____ Print Name: _____ Date: ___/___/___

Signature: _____ Print Name: _____ Date: ___/___/___

I understand that the information provided in this 4 page form is accurate to the best of my knowledge. I know of no reason why I should not participate or volunteer in the activities, equine or otherwise, associated with Ride Your Horse! Therapeutic Riding Program. I agree to abide by all the Standards set forth in the Ride Your Horse! Handbook and I have been informed of these guidelines during my volunteer training session.

Signature: _____ Print Name: _____ Date: ___/___/___

Please note that Ride Your Horse! Therapeutic Riding Program reserves the right to revoke volunteer privileges to anyone who fails to follow the guidelines set forth in the Ride Your Horse! Handbook, especially if the volunteer's conduct negatively impacts the clients', staffs', other volunteers' or animals' safety, privacy, or rights.