Horsin' Around Therapeutic Riding Center
Volunteer Registration Form

Date: _____

General Information

Name:
_____Age_____DOB_____

Address: _____

City:
_____State:_____Zip:_____

Phone :_____(Home)
_____Cell:_____

Email: _____

Occupation_____ Employer/School_____

Parent/ Guardian (if under 18)
_____Phone:_____

How did you learn about Horsin' Around Therapeutic Riding Center?
_____

Check areas of interest:

Program Volunteer	Competition	Administration
__Leading a horse	__Horse Shows	__Public Relations
__Side walking with a student	__Special Olympics	__Fund Raising
__Stable Management		__Volunteer Recruitment
		__Photography
		__Newsletter

Health Information

Please describe any medical condition you may have regarding the physical and/ or emotional demands of working with our therapeutic riding center where volunteer activities may include walking for extended periods of time, jogging short distances, working in hot/ humid/cold conditions and working with large animals.

_____
_____
_____

Signature: _____
(Volunteer)

Signature: _____
Parent/ Guardian (if volunteer is under age 18)

_____
Address (If different from above)

Back Ground Information

Have you ever been charged with or convicted of a crime? ___YES___NO

If yes please explain:
_____
_____
_____

I,_____, authorize Horsin' Around Therapeutic Riding Center to receive information from any law enforcement agency, including but not limited to, police departments and sheriffs departments of this state and any other state or federal government, to the extent permitted by state and federal law, pertaining to any convictions I may have for violation of state or federal criminal laws, including, but not limited to, convictions for crimes committed against/ upon children.

In respect to **Horsin' Around Therapeutic Riding Center's** Confidentiality Policy, I understand that such access is for purposes of considering my application as a volunteer, and that I expressly DO NOT authorize **Horsin' Around Therapeutic Riding Center**, its directors, officers employees or other volunteers to disseminate this information in any way to any other individual, group, agency, organization or corporation.

Date: _____

Signature: _____

Signature: _____
Parent/Guardian (if volunteer is under the age of 18)

Horsin' Around Therapeutic Riding Center uses the above information to locate the best qualified volunteers and does not discriminate based on race, color, creed, sex, national origin or religion. All lesson volunteers must be at least 14 years of age in compliance with North American Riding for The Handicapped Association's (NARHA'S) Centers Standards.

Horsin' Around Therapeutic Riding Center

Volunteer Liability Release

I, _____, would like to volunteer in the **Horsin' Around Therapeutic**

Riding Center's programs. I acknowledge and understand the risks and the potential for risks of a horseback riding program. However, I feel the possible benefits to myself/minor child are greater than the risks assumed. I hereby, intending to be legally bound, for myself, my heirs, and assigns, executors or administrators, waive and release forever all claims for damages against the **Horsin' Around Therapeutic Riding Center**, its board of directors, owners, instructors, therapists, volunteers and / or employees for any and all injuries and/or losses I may sustain while participating in the **Horsin' Around Therapeutic Riding Center's** programs.

Date: _____ Signature: _____
(Volunteer)

AGE: _____ DOB: _____ Signature: _____
Parent/ Guardian (if Volunteer is under 18)

Address: _____

City/State/Zip: _____

Photo Release

_____ I Do consent to and authorize the **Horsin' Around Therapeutic Riding Center** to take or have taken still and/ or moving photographs, films, and / or television pictures, and consent and authorize **Horsin' Around Therapeutic Riding Center,** and/ or its advertising agencies, news media and any other persons associated with **Horsin' Around Therapeutic Riding Center**, to use and reproduce the photographs, films, and/or pictures and to circulate and publicize the same by all means, including, without limiting the generality of the foregoing, newspapers, television media, brochures, inducements or promises have been made to us to secure my signature to this release other than the intention of the **Horsin' Around Therapeutic Riding Center** to use or cause to be used such photographs, films and pictures for the primary purpose of promoting and aiding the center and its work..

Date: _____ Signature: _____
(Volunteer)

Signature: _____
(Parent/ Guardian (IF Volunteer is under 18)

_____ I DO NOT, reasons I am not obligated to disclose, give consent for photographs, either still or moving, or any television or news media, to be taken of myself by the **Horsin' Around Therapeutic Riding Center** or any persons working on behalf of said center. I understand a Red Dot will be placed on the sign-in sheet to reflect photographs, Ect. Are not allowed.

Date: _____ Signature: _____
(Volunteer)

Signature: _____
Parent/Guardian (if Volunteer is under the age of 18)

Horsin' Around Therapeutic Riding Center

Confidentiality Policy

Due to the nature of therapeutic Riding, it is the policy of the **Horsin' Around Therapeutic Riding Center** that any and all information pertaining to our riders, their family, and volunteers shall remain privileged and confidential. This information may include, but is not limited to, any medical, social, referral, personal, and/or financial information that may be disclosed as a result of participation at the center.

Disclosure of any confidential information shall not be released to anyone not associated with **Horsin' Around Therapeutic Riding Center**. Discussions involving any rider shall be limited to progress reports, appropriate mounted and unmounted safety guidelines and any other guidelines the instructor may deem appropriate in each situation. Volunteers will be given information on a need to know basis and in keeping with the confidential nature of our client's records. Each rider shall be assured of record confidentiality and as such, only authorized staff will have access to secure records location. Volunteers are not permitted to discuss riders with other volunteers, their parent or guardians, other instructors, friends, family ect., outside the center.

Interviews or other forms of public discussions with any public relations media; either through television, radio or any other type of publications is strictly prohibited by any volunteer. All such matters should be directed to the Program Director for appropriate action.

Since our intentions are to safeguard our riders, this policy is designed to ensure that the privacy of our riders, their families, and volunteers is protected. Sensitive medical, psychiatric, psychological and/ or personal information may be detrimental if released to those outside **Horsin' Around Therapeutic Riding Center**. Such a breech of confidentiality may also constitute grounds for legal action.
Failure to adhere to the **Horsin' Around Therapeutic Riding Center** confidentiality policy by any staff, volunteer, may result in termination of service with the center and corrective actions taken.

I, _____ agree to uphold the confidentiality policy as stated above.

_____ _____
Volunteer Signature Date

_____ _____
Parent/ Guardian (if minor under age of 18) Date

Horsin' Around Therapeutic Riding Center
Volunteer and Personnel
Authorization For Emergency Medical Treatment

In the event emergency medical aid/ treatment is required due to illness or injury during the course of Volunteering with **Horsin' Around Therapeutic Riding Center**, either on said center site or at an off- site activity and/ or competition, I, _____, hereby authorize the Horsin' Around Therapeutic Riding Center to:

1. Secure and retain medical treatment and transportation if needed.
2. Release all relevant records upon request to the authorized individual or agency involved in the medical emergency treatment.

Name: _____ Age: _____ DOB: _____

Street Address: _____

City/ State/Zip: _____ Telephone: _____

In The event I am unconscious and unable to act for myself, please contact:

Name: _____ Telephone: _____

Relationship: _____ (Must be Parent/ Guardian if under 18)

Physician's Name _____ Telephone: _____

Medical Facility: _____ Telephone: _____

Health Insurance Company: _____ Telephone: _____

Policy Number: _____

In an effort to provide the best care possible, please indicate below if any of the following apply:

___ I am allergic to the following: _____

__ I have the following on going medical conditions:
_____
_____

__ I Have been treated recently for the following physical/ mental condition:
_____
_____

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 person above is unable to be reached.

Date: _____ Consent Signature: _____
(Volunteer or Employee)

Consent Signature: _____
Parent/ Guardian (if Volunteer is under the age of 18)

NON- CONSENT FOR MEDICAL TREATMENT AUTHORIZATION

I, _____, DO NOT give my consent for emergency medical treatment/aid in the case of illness or injury during the course of volunteering or while being on the premises of the Horsin'' Around Therapeutic Riding Center. I fully release the center and/ or its representatives for any injuries/ losses I may incur as a result of this non-consent. In the event that emergency treatment/ aid is required, I wish the following procedure to take
place:_____
_____
_____
_____

Date: _____ Signature: _____
(Volunteer or Employee)

Signature: _____
Parent/ Guardian (if under the age of 18)