Therapeutic Riding Center

Volunteer/Staff Name ____

This file contains the following completed forms:

- ❍ Information Form and Health History
- ❍ Authorization for Emergency Medical Treatment Form
- ❍ Information Release
- ❍ Volunteer/Staff Liability Release Form
- ❍ Photo/Video Release
- ❍ Photo of Horse taken

Notes: ____

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- ❍ Copy on-site
- ❍ Entered into database
- ❍ File Made

Therapeutic Riding Center

Volunteer/Staff Information Form and Health History

General Information

Name: ______________________________ Date: ____________

Address: ______________________________

City: ____________________ ST: ________ Zip: ______________

Date of Birth: ______________ Email: ______________________

Phone: (H) ____________________ (C) ______________________

Last Tetanus Shot: __________ Tuberculosis Test + — Date: ______________

(Consult your physician or local health department if you are not up to date with these shots/tests)

Health History

Please describe your current health status, particularly regarding the physical/emotional demands of working in an equine assisted program. Address fitness, cardiac, respiratory, bone or joint function, recent hospitalizations/surgeries, or lifestyle changes.

____

Allergies: ____

Medications: ____

Volunteers

Check areas in which you are interested:

Program	Special Events	Administration
❍ Horse Handling	❍ Horse Show	❍ Public Relations
❍ Sidewalking with a Student	❍ Fundraising	❍ Photography/Video
❍ Stable Management	❍ Special Olympics	❍ Grant Writing
❍ Facility Repairs	❍ Trail Rides	❍ Budget & Finance

I understand that the information provided above is accurate to the best of my knowledge. I know of no reason why I should not participate in this center's program.

Signature: ______________________________ Date: ____________

(volunteer/staff/caregiver; signed in presence of center staff)

Confidentiality Agreement

I understand that all information (written and verbal) about participants at this NARHA center is confidential and will not be shared with anyone without the expressed written consent of the participant and their parent/guardian in the case of a minor.

Signature: ______________________________ Date: ______________________

(volunteer/staff)

Therapeutic Riding Center

Authorization for Emergency Medical Treatment Form

❑ Staff ❑ Volunteer

Name: ______________________________ DOB: __________ Phone: ______________

Address: ____

Physician's Name: ____________________ Preferred Medical Facility: ____________________

Health Insurance Company: ______________ Policy #: ______________________________

Allergies to medications: ____

Current medications: ____

In the event of an emergency, contact:

Name: __________________________ Relation: ____________ Phone: ______________

Name: __________________________ Relation: ____________ Phone: ______________

Name: __________________________ Relation: ____________ Phone: ______________

In the event emergency medical aid/treatment is required due to illness or injury during the process of receiving services, or while being on the property of the agency, I authorize PROGRAM NAME to:

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

Consent Plan

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(s) above is unable to be reached.

Consent Signature: ____Date: ____________

Client, Parent or Legal Guardian

____

Signed in presence of center staff

A COPY OF THE COMPLETED MEDICAL/HEALTH HISTORY SHOULD BE ATTACHED TO THIS FORM.

Therapeutic Riding Center

Information Release

I, ___________________________________(volunteer/staff), authorize Enter His Gates Therapeutic Riding Center 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 an employee/volunteer, and I expressly DO NOT authorize the PATH International, Inc. center, 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: ______________________________
(volunteer/staff)

Background Disclosure:
Have you ever been charged with or convicted of a crime? ❍ Y ❍ N Please explain __________________
____

CURRENT DRIVER'S LICENSE ❍ Y ❍ N LICENSE NUMBER_____________________________ STATE _____

Volunteer/Staff Liability Release Form

I would like _____________________ (son, daughter, ward or self) to participate in the Enter His Gates Therapeutic Riding program. I acknowledge that I am aware of the risks and potential risks of working with horses. However, I feel that the possible benefits to myself/my son/my daughter/my ward are greater than the risk assumed. I hereby, intending to be legally bound for myself, my heirs and assigns, executors or administrators do waive and release forever all claims for damages against Enter His Gates Therapeutic Riding program. its Board of Directors, Instructors, Therapists, Aides, Volunteers, landowners and employees for any and all injuries or losses myself/my son/my daughter/my ward may sustain while participating in the Enter His Gates Therapeutic Riding program.

Signature: ____ Date: ___________________
(parent, guardian, or adult volunteer)

Photo/Video Release

I hereby consent to and authorize the taking, use and reproduction of any and all photographs, videos and other audiovisual materials taken by Enter His Gates Therapeutic Riding program of me/my son/my daughter/or ward for promotional printed material, educational activities or any other use for the benefit of the program.

Signature: ____ Date: ___________________
(parent, guardian, or adult volunteer)