LADAWN QUARTER HORSES THERAPEUTIC RIDING CENTER

VOLUNTEER INFORMATION FORM

1) Contact Information:

Nam e: ______________________ **Dat e:** ________

Mailing Address: ____________ **Cit y:** ________ **Stat e:** ________ **Zip Code:** ________

Home Phone: ____________ **Cell Phone:** ____________ **Work Phone:** ____________

Email Address: ______________________

Date of Birth: ______________________

How did you hear about our therapy program? ______________________

Check if you'd like to attend a Volunteer Orientation and take a tour of the facility.

2) Area(s) of interest: (check all that apply)

Program Volunteer	Administration	Maintenance
Leading a horse	Public Relations	Pasture maintenance
Side walking with a student	Fundraising	Barn maintenance
Stable Management	Volunteer Recruitment	Carpentry
Horse Care	Budget and Finance	Equipment Repair
Photography / Video	Future Planning	Other:

3) Experience: please share your experience in each area:

a. Hors es: ______________________

b. Leading horses: ______________________

c. Side walking ______________________

d. People with disabilities: ______________________

4) **Schedule:** please tell us your potential volunteer schedule (days, time ranges):

5) **Photo Release:**

I Consent To/ Do Not Consent To/ and authorize the use and reproduction Ladawn Quarter Horses Therapeutic Riding Center of any and all photographs and any other audio- visual materials taken of me for promotional material, educational activities, exhibitions or for any other uses to benefit the program.

Signature: ____ Date: ______________

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6) HEALTH HISTORY:

Please 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 hospitalization/ surgeries, or lifestyle changes.

Current health status:	
Allergies:	

Signature: ____ Date: ______________

7) Emergency Options: (Consent Plan or Non-Consent Plan)
a. Consent Plan:

In case of emergency, I authorize LADAWN QUARTER HORSES THERAPEUTIC RIDING CENTER to secure medical treatment including x-ray, surgery, hospitalization and medication and any treatment procedure deemed "life saving" by the physician. THIS PROVISION WILL BE INVOLKED ONLY IF THE PERSON (S) BELOW ARE UNABLE TO BE REACHED.

Authorization Includes:

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.

Signature: ____ Date: ______________

Emergency Contact Information:

Name:		**Phone #:**		**Relation:**	
Name:		**Phone #:**		**Relation:**	
Name:		**Phone #:**		**Relations:**	

Health Insurance Company:		**Policy #:**	
Allergies to Medications:			

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Current Medications:			
Physician		Referred Medical Facility:	
Date of Last Tetanus Shot			
Tuberculosis Test and Date:			

b. **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 or while being on the property of the agency. In the event that emergency treatment/aid is required, I wish the following procedure to take place:

____
____
____
____

Signature: ____ Date: _____________

8) Volunteer Liability Release

As a volunteer at LADAWN QUARTER HORSES THERAPEUTIC RIDING CENTER, I acknowledge the risks and potential for risks of a horseback-riding program. However, I feel that the possible benefits to myself and the clients that I work with are greater than the risk 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 LADAWN QUARTER HORSES THERAPEUTIC RIDING CENTER, its board of directors, instructors, therapists, volunteers and / or employees for any and all injuries and / or losses I may sustain while participating at LADAWN QUARTER HORSES THERAPEUTIC RIDING CENTER.

Signature: ____ Date: __________________

9) Background Information

Have you ever been charged with or convicted of a crime (check one)? No
Yes
If yes, please explain:

____
____
____
____
____
____

I, ____________________________ (volunteer/staff), authorize Ladawn Quarter Horses 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.

I understand that such access is for the purpose of considering my application as a volunteer, and that I expressly DO NOT authorize LaDawn 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.

Signature: ____ Date: _________________

Current Driver's License:	No Yes	License Number:		Stat e:	

10) 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 express written consent of the participant and their parent/guardian in the case of a minor.

Signature: ____ Date: _________________

Signature of Parent/Guardian: ____
Date: ____________