



HEALING HORSES THERAPEUTIC RIDING CENTERS Volunteer Registration

General Information

Name: _____ Date: _____

Address: _____ City _____ Zip _____

Phone: (C) _____ (H) _____ (W) _____

Date of Birth: _____

E-mail address: _____

Employer/School: _____ Occupation: _____

Parent/Legal Guardian Name and Address:

Name: _____

Address: _____ City _____ Zip _____

How did you learn about our program? _____

****Volunteer Interest****

- | | | |
|--|---------------------------------------|--|
| <input type="checkbox"/> Lessons | <input type="checkbox"/> Horse Show | <input type="checkbox"/> Public Relations |
| <input type="checkbox"/> Stable/Barn Assistant | <input type="checkbox"/> Fundraising | <input type="checkbox"/> Grant Writing |
| <input type="checkbox"/> Walkalong Volunteer | <input type="checkbox"/> Horse Leader | <input type="checkbox"/> Newsletter |
| <input type="checkbox"/> Volunteer Recruitment | | <input type="checkbox"/> Office/Administration |

I would like to commit to a regular day: _____ and time: _____

In addition to my regular day/time I am willing to be on-call volunteer YES/NO (circle one).

Please list any special skills and talents, (such as sign language, photography, public speaking) that you would like to contribute to our program.

Does your employer give time off to volunteer: _____

Does your company or place of employment have a matching gift program: _____

Would you be willing to present information to your company/place of employment about our program or have a HEALING HORSES representative present? _____



Volunteer/Staff Information Health History

Name: _____

Address: _____

Phone: _____ Date of Birth: _____

Recent medical test: _____ 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

Are there any restrictions regarding your health history that would inhibit your ability to volunteer at HEALING HORSES? Please describe below. Information will be kept confidential.

Allergies:

Medications:

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: _____



HEALING HORSES THERAPEUTIC RIDING CENTERS

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

In the event emergency treatment / aid is required due to illness or injury during the process of receiving services, or being on the property of the agency, I authorize **HEALING HORSES** 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.

Volunteer Name: _____ Phone: _____

Address: _____ City _____ Zip _____

In the event I cannot be reached, contact:

Name: _____ Phone: _____

Name: _____ Phone: _____

Physician's Name: _____ Phone: _____

Preferred Medical Facility: _____

Health Insurance Co.: _____ Policy #: _____

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 listed below is unable to be reached.

Date: _____ Consent Signature: _____
Parent or Guardian if under 18

Print Name: _____ Phone: _____

Address: _____

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 emergency treatment / aid is required, I wish the following procedures to take place:

Date: _____ Non-Consent Signature: _____
Parent or Guardian if under 18

Print Name: _____ Phone: _____

Address: _____



WAIVER AND RELEASE OF LIABILITY FORM

Name of Volunteer (please print): _____

I acknowledge that horseback riding or activities involving horses is an extreme test of a person's physical and mental limits and carries with it the potential for serious injury, personal property loss or even death. Horses are large animals and even the most quiet and calm horse can be unpredictable. I hereby assume the risk of participating in such activities.

I hereby take the following action for myself, my executors, administrators, heirs, next of kin, successors and assigns:

- a) I waive, release and discharge from any and all claims or liabilities for death or personal injury or damages of any kinds, which acts arise out of or relate to my participation in, or my traveling to and from the horseback riding events, the following persons or entities: HEALING HORSES, building or facility lessees, sponsors, and the officers, directors, employees, representatives, instructors and agents of the above.
- b) I agree not to sue any of the persons or entities mentioned above for any of the claims or liabilities that I have waived, released or discharged herein, and
- c) I indemnify and hold harmless the persons or entities mentioned above from any claims made or liabilities assessed against them as results of my actions and any attorney fees or costs incurred by them as a result of my action.

By signing this form, I affirm that I am eighteen (18) years of age or older, I have read this document, and I understand its contents.

Signature of Volunteer (Parent/Guardian if minor)

Date signed

The undersigned (parent/guardian's name:) _____

the parent and natural/legal guardian of (minor's name:) _____ hereby executes the foregoing Waiver and release for and on behalf of the minor named herein. I hereby bind myself and all other assigns to the terms of the Waiver and Release. I represent that I have the legal capacity and authority to act for and on behalf of the minor named herein, and I agree to indemnify and hold harmless the persons and entities mentioned above for any claims or liabilities assessed against them as a result of any insufficiency of my legal capacity or authority to act for or on behalf of the minor in the execution of the Waiver and Release.

Signature of Parent / Guardian

Date signed



Photo Release

I...

- Do
- Do Not

Consent to and authorize the use and reproduction by HEALING HORSES of any and all photographs and any other audio/visual materials taken of me for promotional material, educational activities, and exhibitions or for any other use for the benefits of the center.

Signature: _____ Date: _____

Confidentiality Agreement

I understand that all information (written and verbal) about participants at this NARHA PROGRAM 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 JOB DESCRIPTION

Depending on the skill level of each volunteer their responsibilities will include all or portions of the following:

- ◆ Grooming horses
- ◆ Tacking and untacking horses
- ◆ Grazing horses
- ◆ Assisting in mounting and dismounting of our students
- ◆ Leading horses during lessons
- ◆ Sidewalking with the students during lessons
- ◆ Cleaning tack
- ◆ Cleaning tack room and offices
- ◆ Cleaning and maintaining property
- ◆ Assisting with the small animals
- ◆ Assisting with special programs and projects
- ◆ Office work
- ◆ Other activities

We expect the volunteers to follow all program rules, which include, but are not limited to, the following:

- ◆ No smoking
- ◆ No running
- ◆ No climbing on, through, or over corrals
- ◆ All volunteers must be at least 14 years of age
- ◆ All volunteers must wear closed-toed shoes
- ◆ All volunteers must attend an autism orientation (including informational video on therapeutic riding)

I have read the above and understand my responsibilities as a volunteer. I also understand that I am responsible for contacting HEALING HORSES AT 760.449.4883 when my schedule changes.

Volunteer Signature

Date: _____

Printed Volunteer Name