

.ROCKING HORSE RANCH THERAPEUTIC RIDING PROGRAM, INC.  
1721 BLUE BANKS FARM ROAD  
GREENVILLE, NC 27834

## VOLUNTEER INFORMATION FORM

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone: \_\_\_\_\_ Email: \_\_\_\_\_

Employer: \_\_\_\_\_ Work Telephone: \_\_\_\_\_

If student, name of school: \_\_\_\_\_

How did you learn about Rocking Horse Ranch? \_\_\_\_\_

**Have you had any experiences with horses?:** \_\_\_\_\_ If yes, describe \_\_\_\_\_

Check your areas of interest:

**Lesson Program Volunteer:**

\_\_\_\_ Sidewalking with a student

\_\_\_\_ Leading a horse (requires experience with horses)

**Barn Volunteer:**

\_\_\_\_ Horse Buddy (requires horse experience)

\_\_\_\_ Barn assistant

If you are interested in helping with any administrative activities (fund raising, facility maintenance, publicity, photography, etc), please inform an instructor or the program director

### Liability Release

\_\_\_\_\_ (volunteer's name) would like to participate as a volunteer with the Rocking Horse Ranch Therapeutic Riding Program. I have read the posted liability disclaimer (Chapter 99E of NC Statutes written below) and I acknowledge and accept that there are risks and potential risks involved with horses. 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 RHRTRP, its Board of Directors, Instructors, Therapists, Aides, Volunteers, and/or Employees, and/or the owner of any horses used by the program, for any and all injuries and or losses I/my son/daughter/my ward may sustain while participating in Rocking Horse Ranch Therapeutic Riding Program.

Date: \_\_\_\_\_ Signature: \_\_\_\_\_

(Volunteer or Parent/Guardian if under 18)

### Photo Release (optional)

I hereby consent to and authorize the use and reproduction by Rocking Horse Ranch Therapeutic Riding Program of any and all photographs and any other audiovisual materials checked off below that were taken of me for promotional printed material, educational activities or for any other use for the benefit of the program.

\_\_\_\_ photo \_\_\_\_ video \_\_\_\_ RHR website \_\_\_\_ RHR Social media \_\_\_\_ Student educational project

Date: \_\_\_\_\_ Signature: \_\_\_\_\_

(Volunteer or Parent/Guardian if under 18)

### Privacy Policy

I understand that all information (written or verbal) about RHRTRP students shared with me in order to facilitate safe and effective lessons is confidential and will not be shared with anyone without the expressed written consent of the participant or parent/guardian in the case of a minor.

Date: \_\_\_\_\_ Signature: \_\_\_\_\_

(Volunteer or Parent/Guardian if under 18)

### Receipt of Volunteer Manual (available for download on website at RHRNC.COM)

I have received and read the Volunteer Manual.

Date: \_\_\_\_\_ Signature: \_\_\_\_\_

(Volunteer or Parent/Guardian if under 18)

**WARNING**

**Under North Carolina law, an equine activity sponsor or equine professional is not liable for an injury to or the death of a participant in equine activities resulting exclusively from the inherent risks of equine activities. Chapter 99E of the North Carolina General Statutes.**

**AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT**

**Health History**

Please describe your current health status, particularly regarding the physical/emotional demands of working in an equine assisted activities program. Address fitness, cardiac, respiratory, and orthopedic issues you may have along with any recent hospitalizations/surgical procedures.

---

---

---

Allergies: \_\_\_\_\_

Medications: \_\_\_\_\_

Can you walk for 60 minutes and jog for short distances?: \_\_\_\_\_

Given a chance to change sides frequently, can you hold your arm above shoulder height and support a modest weight?: \_\_\_\_\_

**In the event emergency medical aid/treatment** is required due to illness or injury while being on the property of the agency, I authorize Rocking Horse Ranch Therapeutic Riding Program to:

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

In case of emergency: Contact: \_\_\_\_\_ Telephone: \_\_\_\_\_

**Insurance Information**

Policy Number: \_\_\_\_\_ Company: \_\_\_\_\_

---

**Background Information**

Have you ever been charged with or convicted of a crime?  Yes  No If yes, please explain: \_\_\_\_\_

---

**I authorize Rocking Horse Ranch 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 application as a volunteer, and I expressly DO NOT authorize the PATH Intl. 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:  Yes  No License Number: \_\_\_\_\_ State: \_\_\_\_\_