



Volunteer/Staff Information Form and Health History

GENERAL INFORMATION

Name _____ Date _____

DOB _____ Parent/Legal Guardian _____

Address _____ City _____ State _____ Zip _____

Employer/School _____

Phone _____ Alternative # _____ E-mail _____

Parent to Contact _____ Parent Phone _____

How did you learn about the program? _____

HEALTH HISTORY

Recent medical tests: Last Tetanus Shot _____ Tuberculosis Test +/- Date _____

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

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 hospitalizations/surgeries, or lifestyle changes.

Allergies _____

Medications _____

EXPERIENCE

Any experience with horses? _____

How often do you ride? _____ Do you currently own a horse? _____

Previous volunteer experiences _____

Previous work with the handicapped _____

Background in any medically related field? _____

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 _____

LIABILITY RELEASE

_____ (volunteer/staff) would like to participate in Hope Retreat Ranch's therapeutic riding program. I acknowledge the risks and potential for risks of horseback riding, lesson activities and work around the ranch. 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, waive and release forever all claims for damages against Hope Retreat Ranch, Inc., MD713 LLC, Hope Retreat Ranch's Board of Directors, Instructors, Therapists, Aides, Volunteers and/or Employees for any and all injuries and/or losses I/my son/my daughter/my ward may sustain while participating in the Hope Retreat Ranch's equine assisted therapeutic riding program.

Signature _____ Date _____

(Volunteer/Staff/Parent/Guardian)

PHOTO RELEASE

I DO DO NOT

Consent to and authorize the use and reproduction by Hope Retreat Ranch of any and all photographs and any other audio/visual material taken of me for promotional material, educational activities, and exhibitions or for any other use for the benefit of the program.

Signature _____ Date _____

(Volunteer/Staff/Parent/Guardian)

BACKGROUND INFORMATION

Have you ever been charged with or convicted of a crime? (Y/N)

Please explain _____

I, _____ (volunteer/staff), authorize Hope Retreat Ranch 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 or 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 an employee/volunteer, and that I expressly DO NOT authorize Hope Retreat Ranch, 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)

CURRENT DRIVER'S LICENSE (Y /N)

LICENSE NUMBER _____ STATE _____

CONFIDENTIALITY AGREEMENT

I understand that all information (written and verbal) about participants at Hope Retreat Ranch is confidential and will not be shared with anyone without the express written consent of the participant and their parent/guardian if in the case of a minor.

Signature _____ Date _____

(Volunteer/Staff)

Hope Retreat Ranch

Authorization for Emergency Medical Treatment Form

Participant Staff Volunteer

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 host facility, I authorize Hope Retreat Ranch to:

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

Participant's Name _____

Address _____

City/State/Zip _____

In the event of an emergency, please contact:

Name _____ Phone _____ Relationship _____

Name _____ Phone _____ Relationship _____

Physician's Name _____ Phone _____

Preferred Medical Facility _____

Health Insurance Company _____

Consent Plan

This authorization includes x-ray, surgery, hospitalization, medication and any procedure deemed "life saving" by the physician. This provision will only be invoked if the person listed below is unable to be reached.

Consent Signature: _____ Date _____

(Participant, Parent or Guardian)

Non-Consent Plan

I do not give my permission 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 facility. In the event emergency treatment/aid is required, I wish the following procedures to take place:

Non-Consent Signature _____ Date _____

(Participant, Parent or Guardian)