High Horses
Therapeutic Riding Program

P.O. Box 681,
Norwich, Vermont 05055
www.highhorses.org

Volunteer Application

Name______________________________ Date of Birth ____________ Today's Date ____________

Address ____________________ City ______ State ___ Zip _______ Home Phone ____________

School or Place of Employment ______________________________ Work Phone ____________

Email __________________________________ **I prefer to be contacted by email ___**

Driver's License Number ____________________________ State _______

Have you ever been convicted of a criminal offense? No_____ Yes _____ If yes, when? ____________

Where? ____________ Please explain: ____

The above information may be verified and I give my permission for inquiry to be made as to my suitability to act as a volunteer for High Horses.

SIGNATURE: __________________________________ **DATE:** ____________

SIGNATURE OF PARENT/GUARDIAN: _________________________ **DATE:** ____________
(If volunteer is under 18)

Liability Release: I would like to participate in the High Horses Therapeutic Riding Program. I acknowledge the inherent risk and potential for risks of equine activities. **Warning:** Under Vermont Law, an equine activity sponsor is not liable for an injury to, or the death of, a participant in the equine activities resulting from the inherent risks of equine activities that are obvious and necessary, Pursuant to 12 V.S.A. 1039 – added 1995, No. 136 (ADJ. Sess.), 2. The term "Equine Activity Sponsors" includes High Horses Therapeutic Riding Program and Brookside Farm, their Board of Directors, Instructors, Therapists, Aids, Volunteers, and/or all Employees.

SIGNATURE: __________________________________ **DATE:** ____________

SIGNATURE OF PARENT/GUARDIAN: _________________________ **DATE:** ____________
(If volunteer is under 18)

Photo Release: _____ **I consent to and authorize** _____ **I do not consent to nor do I authorize** the use and reproduction by High Horses Therapeutic Riding Program of any and all photographs and any other audiovisual materials taken of me for promotional printed material, educational activities exhibitions, or for any other use for the benefit of the program.

Acknowledgement of Confidentiality Policy: High Horses Therapeutic Riding Program shall preserve the right of confidentiality for all individuals in its program. Anyone who works or volunteers for, or provides services to, High Horses Therapeutic Riding Program shall keep confidential all medical, social, referral, personal and financial information regarding a person and his/her family. Any confidential information can only be used for a specific identified purpose when written authorization is given by a participant, family member or legal guardian. I understand that I will be accountable for the protection of our riders' privacy. Violation of the right to confidentiality will constitute grounds for termination of employment or involvement with High Horses Therapeutic Riding Program.
The undersigned acknowledges that he/she has read this Volunteer application in its entirety; that he/she understands the terms of this release and has signed this release voluntarily and with full knowledge of the effects thereof.

SIGNATURE: __________________________________ **DATE:** ____________

SIGNATURE OF PARENT/GUARDIAN: _________________________ **DATE:** ____________
(BOTH signatures are required if volunteer is under 16 years of age)

(Updated 03/08)

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Authorization for Emergency Medical Treatment

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 **High Horses 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 medical emergency treatment.

Name: ______________________ Phone: ______________ DOB : __________

In case of Emergency, contact: ________________________ Phone : __________

Physician's Name: ______________________________ Phone : __________

Preferred Medical Facility : __________ Health Insurance Carrier : __________ Policy # ________

Medical conditions, medications or allergies we should know about: ____________________

____

____

Consent Plan: (To be invoked in the event that your Emergency Contact cannot be reached.)
I give consent for emergency medical treatment/aid (including x-ray, surgery, hospitalization, medication and any treatment procedure deemed "life saving" by the physician) in the event of illness or injury while on the property of High Horses.

CONSENT SIGNATURE: ____________________________ **DATE:** __________

CONSENT SIGNATURE OF PARENT/GUARDIAN: ____________________ **DATE:** __________
(If volunteer is under 18)

Non-Consent Plan:
I <u>do not</u> give my consent for emergency medical treatment/aid in the case of illness or injury while on the property of High Horses. In the event emergency treatment/aid is required, I wish the following procedure(s) to take place: ____

NON-CONSENT SIGNATURE: ____________________________ **DATE:** __________

NON-CONSENT SIGNATURE OF PARENT/GUARDIAN: __________________ **DATE:** __________
(If volunteer is under 18)

General Information: Please tell us of your experience with:

Horses: ____

Leading Horses and/or Sidewalking: ________________________________

People with Disabilities: _______________________________________

Please check which areas you are interested in:

____ Working in the ring ____ Tack Cleaning ____ Volunteer Support Committee

____ Special Events ____ Ride-A-Thon ____ Horse Show

____ Transporting Horses ____ Horse Committee ____ Fund Raising Committee

____ Newsletter ____ Web Site upkeep ____ Grant Writing ____ Publicity

____ Other (Please Explain) ____

(Updated 03/08)