North American
Riding for the
Handicapped
Member Center

Volunteer/Staff Information Form and Health History

General information

Name: ______________________________ Date: ______________________________

Address: ______________________________

Date of Birth: __________ Phone: (H) ______________________ (W) ______________________

Employer/School: ______________________________

Address: ______________________________

Parent/Legal Guardian Name and Address: ______________________________

____

How did you learn about the program? ______________________________

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)

Health History

Please describe your current health status, particularly regarding the physical/emotional demands of working in an equine assisted program. Address fitness, cardiac, respiratory, bone or joint function, recent hospitalizations/surgeries, or lifestyle changes.

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Allergies: ______________________________

____

Medications: ______________________________

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Check which areas you are interested in:

Program
- ☐ Horse handling
- ☐ Sidewalking with a student
- ☐ Stable management
- ☐ Facility Repairs

- ☐ Special Events
- ☐ Horse Show
- ☐ Fundraising
- ☐ Special Olympics
- ☐ Trail Rides

- ☐ Administration
- ☐ Public Relations
- ☐ Grant Writing
- ☐ Newsletter
- ☐ Volunteer Recruitment

- ☐ Photography/Video
- ☐ Budget & Finance
- ☐ Future Planning

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: ______________________________

(volunteer/staff; signed in presence of center staff)

Volunteer/Staff Information Form and Health History - Page 2

Name:____

Address: ____

Phone:____________________ Date of Birth: ____________________

Photo Release

I, ☐ DO
☐ DO NOT

consent to and authorize the use and reproduction by **Partners Therapeutic Horsemanship** of any and all photographs and any other audio/visual materials taken of me for promotional material, educational activities, exhibitions or for any other use for the benefit of the center.

Signature: ______________________________ Date: ________________

Background Information

Have you ever been charged with or convicted of a crime? Y N; please explain .

____

____

I,____________________(volunteer/staff), authorize **Partners Therapeutic Horsemanship** 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 an employee/volunteer, and that I expressly DO NOT authorize the NARHA 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:________________
(volunteer/staff)

CURRENT DRIVER'S LICENSE Y N LICENSE NUMBER ____________________ STATE_______

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 expressed written consent of the participant and their parent/guardian in the case of a minor.

Signature: _____ ______________________________ Date: ________________
(volunteer/staff)

North American Riding
for the Handicapped
Association

Partners Therapeutic Horsemanship

Volunteer's Authorization for Emergency Medical Treatment Form

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 Partners Therapeutic Horsemanship to secure and retain medical treatment and transportation if needed.

Volunteer's Name: ____ Phone: ________

Address: ____

In the event I cannot be reached, contact: ______________________ Phone: _______

contact: ______________________ Phone: _______

Physician's Name: ____

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 below is unable to be reached.

Date: _______________ Consent Signature: ____

Volunteer, Parent or Guardian

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:

____

____

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Date: ____________ Non-Consent Signature: ____

Volunteer, Parent or Guardian

Print Name: ____________________________________ Phone: ____________________

Address: ____