1591 Big Branch Rd.
Middleburg, FL 32068
(904) 291-6784

Volunteer/Rider's Registration and Release Form

Registration

Name _____ Date _____

Salutation _____ Date of Birth _____ Age _____

Address _____ City _____ State/Zip _____

Cell Phone _____ Home _____ Work _____

E-mail _____

School/Institute presently attending or Employer _____

Parent/ Legal Guardian _____

Address/Phone _____

In case of emergency Contact _____ Phone _____

Contact _____ Phone _____

Would you like to receive our newsletter? No Yes: E-mailed or Mailed (Please circle your preference)

How did you learn about the program? _____

Check which areas you are interested in:

☐ Horse Handling	☐ Sidewalking with Client	☐ Stable Management	☐ Facility Repairs
☐ Horse Shows	☐ Trail Rides	☐ Photography/Video	☐ Fundraising
☐ Grant Writing	☐ Volunteer Recruitment	☐ Public Relations	☐ Computer Work

Liability Release

_____ (Name) would like to participate in the HOPE THERAPY program. I acknowledge the risk and potential risks of horseback riding. However, I feel that the possible benefits to myself/my son/ me 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 THERAPY, its Board of Directors, Instructors, Therapists, Aids, Volunteers, and/or Employees for participating in the HOPE THERAPY program.

Date_____ **Signature** _____

Photo Release

I hereby consent to authorize the use of reproduction by Hope Therapy of any and all photographs and any other audiovisual materials taken of me/my son/my daughter/my ward for promotional printed material, educational activities of any other use for the benefit of the program.

Date_____ **Signature** _____

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Volunteer/Staff Information Form and Health History

General Information

Name _____ Date of Birth _____

Address _____

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

Parent/Legal Guardian Name and Address _____

_____

Have you ever been charged with or convicted of a crime? ☐ **No** ☐ **Yes**

If yes, please explain: _____

I, _____ (*volunteer/staff*), authorize Hope Therapy 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 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/employee. And I expressly DO NOT authorize Hope Therapy, its directors, officers, employees or other volunteers to disseminate this information in any way to any other individual, group, agency, organization or corporation.

Date_____ **Signature** _____

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.

_____

_____

_____

Allergies _____

Medications _____

Last Tetanus Shot Date _____ *Consult your physician or local health department if you are not up to date with these shots.*

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.

Date_____ **Signature** _____

(Volunteer/Staff: signed in presence of center staff)

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Volunteer Authorization for Emergency Medical Treatment

In the event emergency medical 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 Hope Therapy 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 treatment.

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** _____

Print Name _____ **Phone** _____

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 _____ **Consent Signature** _____

Print Name _____ **Phone** _____

Address _____

A COPY OF THE COMPLETED MEDICAL HISTORY SHOULD BE ATTACHED TO THIS FORM