Chariot Riders

Equestrian/Therapeutic Academy for Everyone!

Volunteer/Staff Information Form and Health History

Participant:			Date:
Address:	City:	State:	Zip:
DOB:	Phone: (H)	Phone: (C)	
Employer/School:			Phone:
Address:	City:	State:	Zip:
Parent/Legal Guardian			Phone:
Address:	City:	State:	Zip:
How did you hear about our program?			
Recent medical tests**: (Consult your physician or local health department if you are not up to date with these shots/tests)**			
Last Tetanus Shot:	Tuberculosis Test & Date:		

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:
Current Medications:

Check which areas you are interested in:

✓	**Program**	✓	**Special Events**	✓	**Administration**		
	Horse Handling		Horse Show		Public Relations		Photography/Video
	Sidewalking with a Student		Fundraising		Grant Writing		Budget & Finance
	Stable Management		Special Olympics		Newsletter		Future Planning
	Facility Repairs		Trail Rides		Volunteer Recruitment		

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 Information Form and Health History

Participant:				Date:
Address:		City:	State:	Zip:
Phone:	Email:			DOB:

Photo Release

I DO DO NOT consent to and authorize the use and reproduction by ***Chariot Riders Inc.*** 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? Yes No; please explain

I authorize ***Chariot Riders Inc.*** 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 PATH 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:

Confidentiality Agreement

I understand that all information (written and verbal) about participants at this PATH 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:

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Authorization for Emergency Medical Treatment

<table>
<tr><td colspan="3">Name:</td><td colspan="3">Participant Staff Volunteer</td></tr>
<tr><td>DOB:</td><td colspan="5">Phone:</td></tr>
<tr><td>Address:</td><td colspan="3">City:</td><td>State:</td><td>Zip:</td></tr>
<tr><td colspan="2">Physician's Name:</td><td colspan="4">Preferred Medical Facility:</td></tr>
<tr><td colspan="3">Health Insurance Company:</td><td colspan="3">Policy #:</td></tr>
<tr><td colspan="6">Allergies to medications:</td></tr>
<tr><td colspan="6">Current Medications:</td></tr>
<tr><td colspan="6">In the event of emergency, contact:</td></tr>
<tr><td colspan="2">Name:</td><td colspan="2">Relation:</td><td colspan="2">Phone:</td></tr>
<tr><td colspan="2">Name:</td><td colspan="2">Relation:</td><td colspan="2">Phone:</td></tr>
<tr><td colspan="2">Name:</td><td colspan="2">Relation:</td><td colspan="2">Phone:</td></tr>
</table>

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 Chariot Riders Inc.,

I authorize *Chariot Riders Inc.* 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 emergency treatment.

Consent Plan

This authorization includes x-ray, surgery, hospitalization, medication and any treatment procedure deemed "lifesaving" by the physician. This provision will only be invoked if the person(s) above is unable to be reached.

Date: __________________ Consent Signature: ____
Client, Parent or Legal Guardian

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.

- Parent or legal guardian will always remain on site during equine assisted activities
- In the event emergency treatment/aid is required, I wish the following procedure to take place:

Date: ____________________ Consent Signature: ____
Client, Parent or Legal Guardian

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Client Liability Release

I/my son/my daughter/my ward would like to participate in the **Chariot Riders Inc.** program(s). I acknowledge the risks and potential for risks of engaging in horseback riding activities as well as activities in close proximity to horses. However, I feel that the possible benefits to me/my son/my daughter/my ward are greater than the risks assumed. I hereby, intending to be legally bound, for myself, my heirs and assigns, executors and/or administrators, waive and release forever all claims for damages against **Chariot Riders Inc.**, its Board of Directors, Instructors, Therapists, Aides, Volunteers, and/or Employees for any and all injuries and/or losses that I/my son/my daughter/my ward may sustain while participating in activities at **Chariot Riders Inc**.

Print name:	Date:
Caregiver/Client/Legal guardian consent signature:	

Photo Release

I hereby: (choose one)

consent to and authorize **do not consent** to or authorize

the use and reproduction by **Chariot Riders Inc.** of any and all photographs and any other audio-visual materials taken of me for promotional material, educational activities, and exhibitions or for any other use for the benefit of the program.

Print name:	Date:
Caregiver/Client/Legal guardian consent signature:	