



# VOLUNTEER/STAFF INFORMATION & HEALTH FORM



VOLUNTEER NAME \_\_\_\_\_ DOB: \_\_\_\_\_

GENDER: M F HOME PHONE: (\_\_\_\_) \_\_\_\_\_ WORK PHONE: (\_\_\_\_) \_\_\_\_\_ EMERGENCY (\_\_\_\_) \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ ZIP: \_\_\_\_\_

PARENTS OR GUARDIAN \_\_\_\_\_

ADDRESS(if different from above): \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

EMPLOYER/SCHOOL \_\_\_\_\_

HAVE YOU EVER RIDDEN A HORSE: YES NO HAVE YOU EVER BEEN AROUND HORSES BEFORE: YES NO

How did you hear about the program?: \_\_\_\_\_

What is your availability? \_\_\_\_\_

Describe your health, particularly in horse related activities (ie allergies, walking, heavy lifting ability.. etc)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Activities you are interested in: *Check all that apply*

- |   |  |  |  |
|---|--|--|--|
| <input type="checkbox"/> <u>Program</u>             | <input type="checkbox"/> <u>Special Events</u> | <input type="checkbox"/> <u>Administrative</u> | <input type="checkbox"/> Future Planning |
| <input type="checkbox"/> Sidewalking with a Student | <input type="checkbox"/> Fundraising           | <input type="checkbox"/> Volunteer Coordinator |  |
| <input type="checkbox"/> Horse Handling             | <input type="checkbox"/> Trail Ride            | <input type="checkbox"/> Public Relations      |  |
| <input type="checkbox"/> Greeter                    |  | <input type="checkbox"/> Committees            |  |

Please check the box next to each of these terms if you agree.

**Participant Liability Release**

As staff/volunteer at *Riding For Dreams Therapeutic Riding Program* I acknowledge the risks and potential for risks of a horseback riding program. However, I feel that the possible benefits to myself and the clients I work with are greater than the risk. Thereby, intending to be legally bound, for myself, my heirs and assigns, executors or administrators, released forever all claims for damages against *Riding For Dreams Therapeutic Riding Program*, its Board of Directors, instructors, volunteers and/or employees for any and all injuries and/or losses I may sustain while participating at *Riding For Dreams Therapeutic Riding Program*. *Riding For Dreams Therapeutic Riding Program* also falls under the North Dakota Statutes NDCC 53-10-01 and NDCC 53-10-02. (The summary of the North Dakota Equine Century Codes are found under the *Riding For Dreams Policies and Procedures*.)

**Photo Release**

- I  DO  
 DO NOT

Consent to and authorize the use and reproduction by *Riding For Dreams Therapeutic Riding Program* 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 program. This is valid for one year and can be revoked at my request in writing.

**Policies and Procedures**

I have read the attached instructions and fully understand the policies, standards and rules put in place by *Riding For Dreams Therapeutic Riding Program* and agree to comply with them as stated. This is valid for one year and cannot be revoked.

**Confidentiality**

It is the policy of *Riding For Dreams Therapeutic Riding Program* to preserve the right of confidentiality for all individuals in the program. This policy applies to all staff, volunteers, board members, and participants and their family/ guardians. This policy also restricts to photos being taken during lessons. No pictures may be taken unless otherwise authorized by the *Riding For Dreams Therapeutic Riding Program* President.

By signing this form you are agreeing to these terms set forth between you and *Riding For Dreams Therapeutic Riding Program*.

Signature: _____	Date: _____
Signature of Parent/Guardian (if under 18): _____	Date: _____
Print Name: _____	