Little Britches Therapeutic Riding

A Certified Therapeutic Riding Program

VOLUNTEER INFORMATION FORM

Name: _____

Home Phone: _____ Cell Phone :_____ Work Phone: _____

Email: _____

Mailing Address : _____

City: _____ State: _____ Zip: _____

Date of Birth: _____

Parent/Guardian Name and Address (if under 18) _____

_____

If student, name of school: _____ City: _____

VOLUNTEER LIABILITY RELEASE

As a volunteer at Little Britches Therapeutic Riding, Inc., 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 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 Little Britches Therapeutic Riding, Inc., its board of directors, instructors, therapists, volunteers and/or employees for any and all injuries and/or losses I may sustain while participating at Little Britches Therapeutic Riding, Inc.

Date: _____ Name (print):_____

Signature: _____

Parent/Guardian signature (if under 18):_____

PHOTO RELEASE

I consent to and authorize the use and reproduction by Little Britches Therapeutic Riding, 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 program.

Date: _____ Signature: _____

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Volunteer's Authorization for Emergency Medical Treatment Form

In the event of 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 Little Britches Therapeutic Riding, Inc. to secure and retain medical treatment if needed.

Volunteer's Name:_____

Emergency Contact: _____ Phone: _____ Phone:_____

Emergency Contact: _____ Phone: _____ Phone:_____

Physician's Name: _____

Preferred Medical Facility: _____

Health Insurance Co.: _____ Policy # _____

Consent Plan

This authorization includes x-ray, surgery, hospitalization, medication and any treatment procedures 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 if under 18)

Print Name: _____

Non-Consent Plan

I do not give my consent for emergency medical treatment 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: _____ Non-Consent Signature: _____

Volunteer (Parent or Guardian if under 18)

Print Name: _____