Medicine Horse Center

Equine Assisted Therapies
P.O. Box 1074, Mancos, CO 81328
Tel: 970-533-7403 Fax: 970-533-7405

VOLUNTEERS ARE A VITAL PART OF OUR TEAM.

WE THANK YOU FOR APPLYING FOR VOLUNTEER STATUS

AT MEDICINE HORSE CENTER.

The highest reward of a person's work is not what they get from it,

But what they become because of it.

-- John Ruskin

All forms must be completed in their entirety and mailed or faxed to Medicine Horse Center Headquarters prior to completing mandatory Center volunteer training:

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Or fax: 970-533-7405

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Volunteer/Staff Information Form and Health History

*All medical information is considered confidential and is kept on file by the Medicine Horse Center in case of an emergency.

Staff Volunteer *(Check One)* Date: _____

MANDATORY BACKGROUND CHECKS WILL BE PERFORMED ON ALL PERSONNEL.

PLEASE PROVIDE YOUR SOCIAL SECURITY # _____-_____-_____ *PREVIOUS STATE LIVED IN BEFORE CO:*

General Information

Name: _____**DOB**: _____ **Gender:** M or F

Please fill in all contact phone numbers and circle the best number at which to reach you:

Phone (H): _____ (W): _____ (M): _____

Mailing Address (Street/P.O. Box, City, State, Zip):

_____

E-Mail Address: _____

Employer/School: _____Address: _____

Parent/Legal Guardian Name and Address and Phone Number:

_____

How did you learn about the program?

_____

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.

_____

_____

_____

Recent medical tests: *Last Tetanus Shot*: _____ *Tuberculosis Test + or –* Date: _____

(Consult your physician or local health department if you are not up to date with these shots/tests)

Allergies (Medications, Food, Environmental):_____

Medications:_____

Check which areas you are interested in (check all that apply):

Sidewalking Horse Leader Stable/Horse Care Facility Repairs/Maintenance Landscaping

General Office Duties Public Relations Newsletter Volunteer Recruitment Fundraising Grant Writing

Special Events Photography/Video Other _____

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: _____

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Authorization for Emergency Medical Treatment Form

____Participant ____Staff ____Volunteer

Name: _____ **DOB:** _____ **Phone**: _____
Address: _____
Physician's Name: _____Phone #_____
Preferred Medical Facility:_____
Health Insurance Co.: _____ Policy #: _____
Group # _____Telephone # _____

In the event of an emergency, contact:
Name: _____ Relation: _____ Phone: _____
Name: _____ Relation: _____ Phone: _____
Name: _____ Relation: _____ Phone: _____

In the event emergency medical aid/treatment is required due to illness or injury during the process of receiving services, or

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 "life saving" 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. In the event emergency treatment/aid is required, I wish the following procedure to take place:

_____

_____

Consent Signature: _____ Date: _____
Client, Parent or Legal Guardian

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Release of Liability

As a volunteer at Medicine Horse Center: Therapeutic Riding and Equine Rehabilitation, I, _____ acknowledge the risks of equine assisted therapy programs. However, I do feel that the possible benefits to myself and/or those clients I work with, are greater than the risks assumed. I hereby, intending to be legally bound, for myself, my heirs and assigns, executors or administrators, waive and release directors, officers, instructors, staff, therapists, volunteers, for any and all injuries and/or losses I may sustain while participating in Medicine Horse Center programs.

UNDER COLORADO LAW, AN EQUINE ACTIVITY SPONSOR IS NOT LAIBLE FOR AN INJURY TO, OR THE DEATH OF, A PARTICIPANT IN EQUINE ACTIVITIES RESULTING FROM THE INHERANT RISKS OF EQUINE ACTIVITIES THAT ARE OBVIOUS AND NECESSARY, PURSUANT TO 13-21-119 COLORADO REVISED STATUES

Photo/Press Release

I, _____, hereby give consent to have any and all photographs and any other audio/visual materials taken of me for, but not limited to, promotional material, educational activities, exhibitions or for any other use for the benefit of The Medicine Horse Center: Therapeutic Riding and Equine Rehabilitation. All such materials will be the property of The Medicine Horse Center.

Confidentiality Clause

All information, written and verbal, used in the course of providing equine assisted therapy, is to be treated as strictly confidential by staff, volunteers and instructors. Your signature acknowledges that the information disclosed on client applications, as well as verbal instructions and discussions for lessons/sessions relating to a physical, cognitive or emotional condition, is not to be discussed or disseminated to others.

Name: _____

Signature: _____ Date: _____

_____ _____
Parent/guardian signature (if under 18 years of age) Parent/guardian printed name