MEDICINE HORSE CENTER
Horses Helping People
Equine Assisted Therapies and Experiential Learning
P.O. Box 1074/40700 Road J, Mancos, CO 81328
Tel: 970-533-7403 info@medicinehorsecenter.org

Volunteer 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.

MANDATORY BACKGROUND CHECKS WILL BE PERFORMED ON ALL VOLUNTEERS

PREVIOUS STATES LIVED IN BEFORE CO: _____

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

How do you prefer to be contacted? _____

Phone (H): _____ (W): _____

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

_____

E-Mail Address: _____

Employer/School: _____Address: _____

Parent/Legal Guardian (if under the age of 18) Name/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.

_____

_____

_____

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):_____

_____

Current Medications:_____

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

❑ Facility Repairs/Maintenance ❑ Landscaping ❑ Public Relations ❑ Newsletter ❑ Volunteer Recruitment

❑ Fundraising ❑ 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: _____

Volunteer/Parent or Legal Guardian (if under 18 years of age)

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Authorization for Emergency Medical Treatment Form

Name: _____ **DOB:** _____ **Phone**: _____

Address:_____

Physician's Name: _____Phone #_____
Preferred Medical Facility:_____
Health Insurance Co.: _____ Policy #: _____

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: _____
Volunteer/Parent or Legal Guardian (if under 18 years of age)

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:

_____

_____

Date: _____ Consent Signature: _____
Volunteer/Parent or Legal Guardian (if under 18 years of age)

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Release of Liability

I (or Parent/Legal Guardian's Name), _____ acknowledge the risks of equine assisted therapy programs, however, I 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 forever all claims for damages against Medicine Horse Center, its Board of Directors, Instructors, Therapists, Aides, Volunteers and/or Employees for any and all injuries and/or losses I may sustain while participating in Medicine Horse Center's programs.

Please note:
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 STATUTES

Photo/Press Release

I (or Parent/Legal Guardian's Name), _____, hereby consent to and authorize the use and reproduction by Medicine Horse Center of any and all photographs and any other audiovisual materials taken of me/my child/my ward for promotional printed and/or digital purposes (including social media), educational activities or for any other use for the promotion of Medicine Horse Center and its programs.

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: _____

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