



## Volunteer/Staff Information Form and Health History

### General information

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Phone: (H) \_\_\_\_\_ (W) \_\_\_\_\_

Employer/School: \_\_\_\_\_

Address: \_\_\_\_\_

Parent/Legal Guardian/Caregiver Name /Address/Phone Number: \_\_\_\_\_

How did you learn about the program? \_\_\_\_\_

Recent medical tests: Last Tetanus Shot: \_\_\_\_\_ Tuberculosis Test + -- Date: \_\_\_\_\_

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

### 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: \_\_\_\_\_

Medications: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

### Check which areas you are interested in:

- 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/caregiver; signed in presence of center staff)

*Lend A Hand Therapeutic Riding Foundation*

*151 Laten Knight Road*

*Cranston, Rhode Island 02921*

*(401) 826-9278*

[www.lendahandri.org](http://www.lendahandri.org)



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Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

### Photo Release

I  DO

DO NOT

consent to and authorize the use and reproduction by Lend a Hand Therapeutic Riding Center 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? Y N; please explain \_\_\_\_\_

I, \_\_\_\_\_ (volunteer/staff), authorize Lend a Hand Therapeutic Riding Center 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 Lend a Hand Therapeutic Riding 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: \_\_\_\_\_

(volunteer/staff)

CURRENT DRIVER'S LICENSE Y N LICENSE NUMBER \_\_\_\_\_ STATE \_\_\_\_\_

### Confidentiality Agreement

I understand that all information (written and verbal) about participants at Lend a Hand Therapeutic Riding 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 Form

Participant: \_\_\_\_\_ Staff: \_\_\_\_\_ Volunteer \_\_\_\_\_

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Phone: (H) \_\_\_\_\_ (W) \_\_\_\_\_ (C) \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Email Address: \_\_\_\_\_

Physician's Name: \_\_\_\_\_

Health Insurance Company: \_\_\_\_\_

Policy Number: \_\_\_\_\_

Allergies to medications: \_\_\_\_\_

Current Medications: \_\_\_\_\_

In the event of an emergency, contact:

Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Phone: \_\_\_\_\_

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## **Authorization for Emergency Medical Treatment Form**

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 where the services are provided, I authorize Lend A Hand Therapeutic Riding Foundation, LLC to :

- 1) Secure and retain medical treatment and transportation if needed
- 2) Release client records upon request t 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: \_\_\_\_\_

### **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 procedures to take place:

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Date: \_\_\_\_\_ Consent Signature: \_\_\_\_\_

Client, Parent, or legal Guardian

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## **HOLD HARMLESS AGREEMENT**

In Consideration of the agreement of Lend A Hand Therapeutic Riding Foundation, LLC and Lend A Hand Horse Farm, LLC, to allow me to use its grounds and facilities for horseback riding, I \_\_\_\_\_ being cognizant of the inherent danger of horseback riding and agree with Lend A Hand Therapeutic Riding Foundation, LLC as follows:

- 1) That I understand that it is not the purpose of Lend a Hand Therapeutic Riding Foundation, LLC to teach safety rules, nor is it the function of Lend a Hand Therapeutic Riding Foundation to serve as guardians of my safety. I also understand that I am to furnish my own equipment and that I am responsible for its safety and good operating condition, regardless of where I obtain it.
- 2) That I understand and agree that neither Lend A Hand Therapeutic Riding Foundation, LLC nor its principals, employees, agents, successors, assigns, board of directors, and insurance company, may be held liable in any way for any occurrence in connection with such horseback riding which may result in injury, death, damage or loss to me or my family, my guests, heirs, successors or assigns.
- 3) I agree to assume all risks in connection with such use and I further release aforementioned Lend A Hand Therapeutic Riding Foundation, LLC nor its principals, employees, agents, successors, assigns, board of directors, and insurance company, from any harm, injury, damage, or loss which may occur while I am engaged in such use, including, but not limited to, all risks connected therewith, foreseen or unforeseen; further to save and hold harmless the said Lend A Hand Therapeutic Riding Foundation, LLC nor its principals, employees, agents, successors, assigns, board of directors, and insurance company, from any claim by me or my family, my guests, estates, heirs or assigns, arising out of my use of the Lend A Hand Therapeutic Riding Foundation, LLC facilities and grounds.

UNDER RHODE ISLAND LAW, AN EQUINE PROFESSIONAL, UNLESS HE OR SHE CAN BE SHOWN TO HAVE FAILED TO BE IN THE EXERCISE OF DUE CARE, IS NOT LIABLE FRO AN INJURY TO, OR DEATH OF A PARTICIPANT IN EQUINE ACTIVITIES RESULTING FROM THE INHERENT RISKS OF EQUINE ACTIVITIES, PURSUANT OF THIS CHAPTER.

I further state that I am of lawful age and legally competent to sign this affirmation and hold harmless agreement; that I have been fully informed of its contents; that I understand the terms contained herein are contractual and non mere recital; and that I have signed this document of my own free will.

IN WITNESS WHEREOF, I have executed this affirmation & hold harmless agreement on this:

\_\_\_\_\_ Day of \_\_\_\_\_, Year \_\_\_\_\_

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Signature

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