HORSES FOR HEALING INC

Mailing Address: P.O. Box 1136 * Meadow Vista, CA 95722 * Voice (530) 887-9573
Riding Center: Center Stage * 13355 Bell Brook Drive * Auburn, CA 95602

Volunteer/Staff Information Form and Health History

General information

Name: ____Date: ____________

Address: ____

Date of Birth: ________________ Phone: (H)_________________________ (W) __________________________

(C) _______________________ Email: _______________________ @ ________________________________

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:

Program	Special Events	Administration	
☐ Horse Handling	☐ Horse Show	☐ Public Relations	☐ Photography/Video
☐ Side-walking 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)

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Page 2

Name: ____

Address:____

Phone: ______________________ _________________________Date of Birth: ________________________________

Photo Release

☐ I DO

☐ DO NOT

consent to and authorize the use and reproduction by ______Horses For Healing Therapeutic Riding Center
(PATH Int'l. 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; If yes, please explain

____

____

I, ____ (volunteer/staff), authorize ___Horses For Healing Therapeutic Riding Center___to
(center)

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 PATH INTERNATIONAL 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 this PATH International 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: _________________
(volunteer/staff)

HORSES FOR HEALING

THERAPEUTIC RIDING CENTER

Mailing Address: P.O. Box 1136 * Meadow Vista, CA 95722 * Voice (530) 887-9573

Riding Center: Center Stage * 13355 Bell Brook Drive * Auburn, CA 95602

Authorization for Emergency Medical Treatment Form

□ Participant □ Staff □ Volunteer

Name: ____ DOB: _______________ Phone: __________________________

Address: ____

Physician's Name: ____________________________________ Preferred Medical Facility: _________________________

Health Insurance Company: ___________________________________ Policy #: ________________________________

Allergies to medications: ____

Current medications: ____

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 while being on the property of the agency, I authorize ______Horses For Healing Therapeutic Riding Center__________ to:
(Center's Name)

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.

- □ Parent or Legal Guardian will remain on site at all times during equine-assisted activities
- □ In the event emergency treatment is required, I wish the following procedures to take place:

____

____

____

Date: ___________________ Non-Consent Signature: ____
Client, Parent or Legal Guardian

A COPY OF THE COMPLETED MEDICAL/HEALTH HISTORY SHOULD BE ATTACHED TO THIS FORM.