



# HORSES FOR HEALING INC

Mailing Address: P.O. Box 4839 \* Auburn, CA 95604 \* 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                                 |  |
|--|---|--|--|
| <input type="checkbox"/> Horse Handling              | <input type="checkbox"/> HorseShow        | <input type="checkbox"/> Public Relations      | <input type="checkbox"/> Photography/Video |
| <input type="checkbox"/> Side-walking with a Student | <input type="checkbox"/> Fundraising      | <input type="checkbox"/> Grant Writing         | <input type="checkbox"/> Budget & Finance  |
| <input type="checkbox"/> Stable Management           | <input type="checkbox"/> Special Olympics | <input type="checkbox"/> Newsletter            | <input type="checkbox"/> Future Planning   |
| <input type="checkbox"/> Facility Repairs            | <input type="checkbox"/> Trail Rides      | <input type="checkbox"/> 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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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 4839 \* Auburn, CA 95604 \* 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.