

Volunteer Application

To be completed by the adult volunteer or volunteer's parent.

GENERAL INFORMATION

Volunteer's Name: _____ Date of Birth: _____

Age: _____ Height: _____ Weight: _____ Gender: **M** **F**

(Age/Height/Weight/Gender are important for helping us make horse/client/volunteer team assignments.)

Address: _____

Home Phone: _____ Other Phone: _____ E-mail: _____

Parent/Caregiver Name(s) and Phone Number(s), if under age 18 or dependent adult: _____

Emergency Contact Name and Phone number(s): _____

Employer/School _____

How did you learn about our program? _____

PLEASE CHECK THE DAYS AND TIMES YOU ARE AVAILABLE EACH WEEK:

| Mondays | Tuesdays | Wednesdays | Thursdays | Fridays | Sundays |
|--------------------------------------|--------------------------------------|--------------------------------------|--------------------------------------|--------------------------------------|--------------------------------------|
| <input type="checkbox"/> 8 - 10am | <input type="checkbox"/> 8 - 10am | <input type="checkbox"/> 8 - 10am | <input type="checkbox"/> 8 - 10am | <input type="checkbox"/> 8 - 10am | <input type="checkbox"/> 8 - 10am |
| <input type="checkbox"/> 10am - 12pm | <input type="checkbox"/> 10am - 12pm | <input type="checkbox"/> 10am - 12pm | <input type="checkbox"/> 10am - 12pm | <input type="checkbox"/> 10am - 12pm | <input type="checkbox"/> 10am - 12pm |
| <input type="checkbox"/> 12-2pm | <input type="checkbox"/> 12-2pm | <input type="checkbox"/> 12-2pm | <input type="checkbox"/> 12-2pm | <input type="checkbox"/> 12-2pm | <input type="checkbox"/> 12-2pm |
| <input type="checkbox"/> 2 - 4pm | <input type="checkbox"/> 2 - 4pm | <input type="checkbox"/> 2 - 4pm | <input type="checkbox"/> 2 - 4pm | <input type="checkbox"/> 2 - 4pm | <input type="checkbox"/> 2 - 4pm |

IF YOU CANNOT COMMIT TO VOLUNTEERING ON A WEEKLY BASIS, please indicate the frequency/days/times that you can commit to: _____

HORSE EXPERIENCE

Are you comfortable around horses? ___ No ___ Yes ___ Somewhat. ___ I'm not sure.

Do you or have you owned horses? ___ No ___ Yes For how long? _____

Have you ever worked with horses? ___ No ___ Yes In what capacity? _____

Have you had formal lessons or training in working with horses? ___ No ___ Yes

If yes, please list the type and amount of training you have had: _____

OTHER

Are you comfortable around people with disabilities? ___ No ___ Yes ___ I'm not sure.

Have you ever worked with people with disabilities? ___ No ___ Yes In what capacity? _____

Please describe any special skills, training, or talents that you feel might be helpful to us. _____

Please tell us why you would like to volunteer at The Right Step: _____

HEALTH HISTORY

Please describe your current health status, particularly regarding the physical/emotional demands of working in a therapeutic riding program. Address fitness, cardiac, respiratory, bone or joint function, recent hospitalizations/surgeries, or lifestyle changes. _____

Allergies: _____

Medications: _____

Recent Surgeries/Hospitalizations/Injuries: _____

BACKGROUND INFORMATION

CURRENT DRIVER'S LICENSE NUMBER: _____ STATE: _____

Have you ever been charged with or convicted of a crime? ___ No ___ Yes; please explain _____

I understand that the Right Step at Coventry Farms reserves the right 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. I understand that such access is for the purpose of considering my application as a volunteer, and that I expressly DO NOT authorize the operating 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

TRUTH OF INFORMATION

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

CONFIDENTIALITY AGREEMENT

I understand that all information (written and verbal) about participants at the Right Step at Coventry Farms 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. This includes all medical, social, referral, personal, financial, and otherwise sensitive information. I understand that individuals who breach confidentiality will be removed from the Right Step volunteer program.

Signature

Date

PHOTO RELEASE

I ___ Do ___ Do Not consent to and authorize the use and reproduction by the Heart of Texas 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 program.

Signature

Date

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

To be completed by the adult participant, participant's parent, or participant's legal representative.

Name: _____ DOB: _____

Phone: _____ Alt. Phone _____

Address: _____

Physician's Name: _____ Preferred Medical Facility: _____

Health Insurance Company: _____ Policy Number: _____

Allergies to Medications: _____

Current Medications: _____

In the event of an emergency, contact:

1) Name: _____ Relation: _____ Phone: _____

2) Name: _____ Relation: _____ Phone: _____

3) 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 organization, I authorize The Right Step at Coventry Farms to:

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.

Consent Signature (Signed in presence of center staff)

Date

Non-consent Plan

I do not give my consent for emergency medical treatment or first aid in the event of illness or injury during the process of receiving services or while being on the property of the MANE program. I agree that a parent or legal representative will remain on site at all times during equine assisted activities. In the event emergency treatment or first aid is required, I wish the following procedures to take place:

Non- Consent Signature (Signed in presence of center staff)

Date