

The Buffalo Therapeutic Riding Center



Volunteer/Staff Information

GENERAL INFORMATION

Name: _____ Date: _____

Phone: _____ Alternate#: _____ E-mail: _____

Address: _____

School/Employer: _____

Phone: _____ E-mail: _____

Address: _____

Parent/Legal Guardian: _____

Phone: _____ E-mail: _____ Alternate#: _____

Address (if different than above): _____

Last Tetnus shot: _____ Tuberculosis Test + - Date: _____ Recent Medical 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 and joint function, recent surgeries, hospitalizations or life changes.

Allergies: _____

Medications: _____

Check areas of interest:

Program

- Horse handling
- Sidewalking
- Facility repairs

Special Events

- Horse shows
- Fundraising
- Clinics

Administration

- Public Relations
- Grant writing
- 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 the Buffalo Therapeutic Riding Center's activities.

Signature: _____ Date: _____

(signed by parent or guardian if minor in presence of center staff)

The Buffalo Therapeutic Riding Center

Volunteer/Staff Information Page 2

Name: _____ Date of Birth: _____

Address: _____

Phone: _____ e-mail: _____ Alternate Phone: _____

BACKGROUND INFORMATION

Have you ever been charged with or convicted of a crime? Y N Please Explain

I, _____, authorize the Buffalo Therapeutic Riding Center to receive information from any law enforcement agency, including police departments and sheriff's departments of this state or federal government, to the extent permitted by state and federal laws, pertaining to any conviction I may have had for violations of state and 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 a staff member or volunteer, and I expressly DO NOT authorize the Buffalo Therapeutic Riding Center, its directors, officers, employees or other volunteers to disseminate this information in any way to any other group, agency, organization or corporation.

Signature: _____ Date: _____

(signed by parent or guardian if minor)

Current Driver's License Y N License #: _____ State: _____

PHOTO/AUDI-VISUAL RELEASE

I DO

DO NOT

Consent to and authorize the use and reproduction by the BUFFALO THERAPEUTIC RIDING CENTER and the staff of any and all photographs and any other audio/visual materials taken for promotional material, educational activities, exhibition or for any other use for the benefit of the program, the facility or the staff.

Signature: _____ Date: _____

(Parent or Guardian if minor)

CONFIDENTIALITY AGREEMENT

I understand that all information (written and verbal) about participants at the Buffalo Therapeutic Riding Center is confidential and will NOT be shared with anyone without the express written consent of the participant's parent or guardian.

Signature: _____ Date: _____

Signature of Parent or Guardian: _____ Date: _____

The Buffalo Therapeutic Riding Center



Authorization for Emergency Medical Treatment

Participant Staff Volunteer

Name: _____ DOB: _____ Phone: _____

Address: _____

Physician's Name: _____ Preferred Medical Facility: _____

Health Insurance Company: _____ Policy #: _____

Allergies to Medications: _____

Current Medications: _____

Emergency Contacts:

Name: _____ Relation: _____ Phone: _____

Name: _____ Relation: _____ Phone: _____

Name: _____ Relation: _____ Phone: _____

CONSENT PLAN

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 The Buffalo Therapeutic Riding Center to:

1. Secure and retain medical treatment and transportation if needed.
2. Release client information on request to the authorized individual or agency involved in the medical treatment.

This authorization includes x-rays, 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: _____ Signature _____
(Parent or Legal Guardian if minor)

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 on the property of the agency. In the event emergency medical treatment/aid is required, I wish the following procedures to take place:

Date: _____ Signature _____
(Parent or Legal Guardian if minor)

The Buffalo Therapeutic Riding Center



RELEASE

In consideration of taking lessons, riding horses, and using the facilities at The Buffalo Therapeutic Riding Center / the Buffalo Equestrian Center, Inc., I, individually, and/or as parent /guardian of the below named minor(s), do hereby consent to assume all risks in connection with such lessons, horseback riding, and use of facilities, and agree to waive, release, and discharge The Buffalo Therapeutic Riding Center / The Buffalo Equestrian Center, Inc., its officers, employees, and members, from any and all liability, claims, and actions whatsoever for damages or injury (including fatality) to me and/or said minor(s) by reason of such lessons, horseback riding or use of facilities or otherwise. I further agree to indemnify and hold harmless The Buffalo Therapeutic Riding Center / the Buffalo Equestrian Center, Inc. against any loss or damage which it may sustain in consequence of my use or said minor's use of the horses and facilities and no agreement, either verbal or written, will in a any manner affect this release, which shall be binding upon the heirs, executors and administrators of myself and/or of the said minor(s) listed hereon.

Notarized

Individually and/or parent/guardian
of the following minors

Date