High Horses
Therapeutic Riding Program

P.O. Box 681
Norwich, Vermont 05055
www.HighHorses.org

Volunteer Application

Date: _____

Name_____ Date of Birth _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Other Phone _____Email_____

I prefer to be contacted by: phone ____ email ____ AND to receive mailings by: mail ___ email___

Driver's License Number _____ State _____

Have you ever been convicted of a criminal offense? No____ Yes ____ If yes, when? _____ Where?_____

Please explain:_____

The above information may be verified and I give my permission for inquiry to be made as to my suitability to act as a volunteer for High Horses.

SIGNATURE: _____ DATE: _____

SIGNATURE OF PARENT/GUARDIAN: _____ DATE: _____
(If volunteer is under 18)

Photo Release: _____ I consent to and authorize _____ I do not consent to nor do I authorize
the use and reproduction by High Horses Therapeutic Riding Program of any and all photographs and any other audiovisual materials taken of me for promotional printed material, educational activities exhibitions, or for any other use for the benefit of the program.

Acknowledgement of Confidentiality Policy: High Horses Therapeutic Riding Program shall preserve the right of confidentiality for all individuals in its program. Anyone who works or volunteers for, or provides services to, High Horses Therapeutic Riding Program shall keep confidential all medical, social, referral, personal and financial information regarding a person and his/her family. Any confidential information can only be used for a specific identified purpose when written authorization is given by a participant, family member or legal guardian. I understand that I will be accountable for the protection of our riders' privacy. Violation of the right to confidentiality will constitute grounds for termination of employment or involvement with High Horses Therapeutic Riding Program.
The undersigned acknowledges that he/she has read this Volunteer application in its entirety; that he/she understands the terms of this release and has signed this release voluntarily and with full knowledge of the effects thereof.

SIGNATURE: _____ DATE: _____

SIGNATURE OF PARENT/GUARDIAN: _____ DATE: _____
(BOTH signatures are required if volunteer is under 16 years of age)

Liability Release: I would like to participate in the High Horses Therapeutic Riding Program. I acknowledge the inherent risk and potential for risks of equine activities. **Warning:** Under Vermont Law, an equine activity sponsor is not liable for an injury to, or the death of, a participant in the equine activities resulting from the inherent risks of equine activities that are obvious and necessary, Pursuant to 12 V.S.A. 1039 – added 1995, No. 136 (ADJ. Sess.), 2. The term "Equine Activity Sponsors" includes High Horses Therapeutic Riding Program and Brookside Farm, their Board of Directors, Instructors, Therapists, Aids, Volunteers, and/or all Employees.

SIGNATURE: _____ DATE: _____

SIGNATURE OF PARENT/GUARDIAN: _____ DATE: _____
(If volunteer is under 18)

Volunteer Interests

Returning Volunteers

I have been trained at High Horses to: Sidewalk____ Lead____ Other:_____

I prefer to be scheduled as a: Sidewalker____ Leader____ Any position____ Other:_____

New Volunteers

Experience with Horses:_____

Experience with Disabilities:_____

I am interested in volunteering with: ____Sidewalking ____Leading ____Horse Exercise Program ____Site Improvement

____Tack Cleaning ____Transporting Horses ____Winter Homes for Horses ____Fundraising Committee ____Hoofin' It

____Horse Show ____Special Olympics ____Newsletter ____Website ____Grant Writing ____Special Events

____Other (Please Explain)_____

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Authorization for Emergency Medical Treatment

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 **High Horses Therapeutic Riding Program** to:

1. Secure and retain medical treatment and transportation if needed.
2. Release records upon request to the authorized individual or agency involved in the medical emergency treatment.

Name: _____ Date: _____

Home Phone: _____ DOB : _____

In case of Emergency, contact: _____ Relationship: _____

Primary Phone: _____ Other Phone: _____

Physician's Name: _____ Phone : _____

Preferred Medical Facility: _____

Health Insurance Carrier: _____ Policy # _____

Medical conditions, medications or allergies we should know about: _____

_____

Consent Plan: (To be invoked in the event that your Emergency Contact cannot be reached.)
I give consent for emergency medical treatment/aid (including x-ray, surgery, hospitalization, medication and any treatment procedure deemed "life saving" by the physician) in the event of illness or injury while on the property of High Horses.

CONSENT SIGNATURE: _____ DATE: _____

CONSENT SIGNATURE OF PARENT/GUARDIAN: _____ DATE: _____
(If volunteer is under 18)

Non-Consent Plan:
I do not give my consent for emergency medical treatment/aid in the case of illness or injury while on the property of High Horses. In the event emergency treatment/aid is required, I wish the following procedure(s) to take place:

_____

_____

NON-CONSENT SIGNATURE: _____ DATE: _____

NON-CONSENT SIGNATURE OF PARENT/GUARDIAN: _____ DATE: _____
(If volunteer is under 18)