VOLUNTEER REGISTRATION & RELEASE FORM

PLEASE PRINT

Name _____Date of Birth ____/___/____ Age _____

Address _____

City _____ State_____ Zip_____

Home phone (___) _____ Work phone (___) _____ Cell phone (____)_____

Email _____

Height: _____ Are you able to jog during a lesson? YES / NO (circle)

Place of Employment/School_____ Occupation _____

Parent/ guardian name _____Phone (____)_____
(for volunteers under 18 years of age)

Volunteer Opportunities: Please mark all of the areas you are interested in.

Lesson Team: ___ Leader (additional training necessary)* ___ Side walker

Horses: ___ Groomer* _____Feeder* ____Exerciser*

Other: ____ Fundraising Support ____ Stable hand ___ PR Support _____Rider
____Greeter/hospitality ____Clean tack

Additional Interest_____
*requires horsemanship and/or riding skills

MARK ALL TIMES YOU ARE AVAILABLE: *(ANY ADDITIONAL NOTES MAY BE WRITTEN BELOW)*

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Morning 8-12						
Afternoon 1-5						
Evening 5-8:30						

Notes_____
_____

How many days a week would you want to volunteer? _____
How many hours per day? _____ (Minimum 1hr – Average 3hrs)

DATE: _____ SIGNATURE _____

SIGNATURE OF PARENT/GUARDIAN _____
(If volunteer is under 18, **both** signatures are required)

RELEASES/POLICY OF CONFIDENTIALITY/EMERGENCY MEDICAL

PHOTO RELEASE: (Check one**)** ____ I **consent** to and authorize ____ **I do not** consent to nor do I authorize the use and reproduction by Hope Unbridled Equestrian Program, Inc. of any and all photographs and any other audiovisual materials taken of me for promotional printed materials, educational activities, exhibitions, or for any other use for the benefit of the program.

POLICY OF CONFIDENTIALITY: Confidentiality is defined as "told in secret or private; trusted." Any information regarding the participants (clients) at Hope Unbridled must be held in strict confidentiality. It is critical that we respect each individual. Confidentiality is considered one of the most basic responsibilities of our facility. Failure to abide by this policy may diminish the quality of the services we provide and result in legal ramifications. I have read and understand Hope Unbridle's Policy of Confidentiality and agree to abide by same.

LIABILITY RELEASE: I acknowledge the risks and potential for risks of horseback riding and working with horses, including grievous bodily harm; however, I feel that the possible benefits to me are greater than the risks assumed. I hereby, intending to be legally bound for myself, my heirs and assigns, executors or administrators, waive and release forever all claims for damages against Hope Unbridled Equestrian Program, Inc., its board of directors, Instructors, Therapists, Volunteers, Dream Catcher Stables and its owners, for any and all injuries and/ or losses I may sustain while participating as a Hope Unbridled volunteer or any other related activities at Dream Catcher Stables.

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.*

DATE: _____ SIGNATURE _____

SIGNATURE OF PARENT/GUARDIAN _____
(If volunteer is under 18, **both** signatures are required)

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT FOR VOLUNTEERS
In the event emergency medical aid/treatment is required due to illness or injury while being on the property of the agency, I authorize Hope Unbridled 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.
In case of emergency, contact: _____ Phone _____

Physician's Name: _____ Town _____ Phone _____

Preferred Medical Facility: _____ Health Insurance Carrier: _____ Policy#:_____

Please indicate any medical conditions and or medication that may affect your volunteer role and that we should be aware of in the event of an emergency _____ Date of Last Tetanus shot _____

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 or any treatment procedure deemed "life saving" by the physician) in the event of illness or injury while on the property of the agency.

Date:_____ Consent Signature_____

Signature of Parent/Guardian_____
(If volunteer is under 18 years of age, **both** signatures are required)

NON-CONSENT PLAN I do not give consent for emergency medical treatment/aid in the event of illness or injury while on the property of the agency. In the event emergency treatment/aid is required, I wish the following procedures to take place:
_____

Date: _____ Non-Consent Signature _____

Signature of Parent/Guardian _____

(If volunteer is under 18 years of age, **both** signatures are required)