HEALING BY HORSEBACK

VOLUNTEER APPLICATION AND HEALTH HISTORY

Please Print

Name: _____ DOB: _____ Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Primary Phone: _____ Email: _____

Parent/Legal Guardian Name (if under 18): _____

Preferred method of contact (circle one): phone call text email

How did you learn about us? _____

Do you have experience working with children or adults with disabilities? If so, describe:

_____

Do you own your own horse: **Yes No** Do you have experience working with horses? **Yes No**

Please circle the description that best matches your horsemanship skills:

New or Very little knowledge Beginner Intermediate Advanced Instructor or Clinician

Working in this facility can be physically demanding based upon duty. Please describe your current health status and any limitations in regards to fitness, cardiac, respiratory, bone or joint function, recent hospitalizations or surgeries:

_____

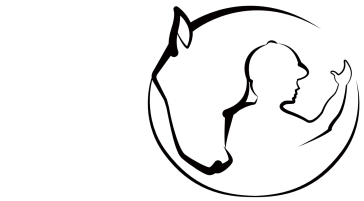
_____

Allergies: _____ Medications: _____

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 facility's program. I have received, read and understand the Healing By Horseback Volunteer Handbook.

Signature: _____ **Date:** _____

If under 18 years of age, Guardian Signature: _____



HEALING BY HORSEBACK

VOLUNTEER BACKGROUND CHECK RELEASE

Name: Last_____First_____ Middle _____

Date of Birth: _____Social Security No.: _____

Driver's License No. and State of Issue:_____

Personal History

Have you ever been arrested or convicted? **Yes No** If yes: **Civil Criminal Misdemeanor Felony**

Nature of crime: _____

Dates of Convictions(s) _____

State, County, City: _____

Please give a detailed explanation:

_____

_____

_____

I understand that HEALING BY HORSEBACK may conduct a background check which could include, but not be limited to, regional, state, and national databases; employment, educational, motor vehicle, felony, misdemeanor and sex offender records. 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 facility's program.

Signature: _____ Date:_____

If under 18 years, Parent/Guardian Signature_____

PHOTO RELEASE

I ____DO ____DO NOT Consent to and authorize the use and reproduction by HEALING BY HORSEBACK 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:_____

If under 18 years, Parent/Guardian Signature_____

HEALING BY HORSEBACK

LIABILITY RELEASE

That I, _____ or that I, the undersigned parent or legal guardian of _____, a minor, for and in sole consideration of the privilege of permitting said person to participate in activities at or sponsored by Healing By Horseback, Inc. and recognizing that horseback riding activities involve certain inherent dangers and risks to persons and property, do hereby agree to assume for myself and on behalf of my ward or child, the risks and dangers attendant to such activity, including but not limited to: falling or being thrown from a horse, being kicked, stepped on or bitten by a horse or other animal, and/or injuries sustained while riding, mounting or dismounting a horse. I further acknowledge the risks and potential for risks associated with recreational and outdoor activities, including but not limited to: snake, animal or insect bites; uneven ground; sun, cold and wind exposure; cuts and scrapes; sore or pulled muscles; broken, dislocated or fractured bones; nerve damage; internal injuries; head injuries; grievous bodily injury or death. However, I feel that the possible benefits to myself, child or ward are greater than the risk assumed.

I hereby, intending to be legally bound, for myself and my child or ward, heirs and assigns, executors or administrator, waive and forever release, acquit, discharge and hold harmless all claims for damages against Healing By Horseback, Inc. its board of directors, trustees, agents, instructors, therapists, employees, representatives, volunteers, owners of property on which Healing By Horseback, Inc. operates, successors or assigns on account of any personal injuries and/or personal damages known or unknown, or in anyway growing out of, the acts of Healing By Horseback, Inc., its board of directors, trustees, agents, instructors, therapists, aids, employees, representatives, volunteers, owners of property on which Healing By Horseback, Inc. operates, successors or assigns.

WARNING

I understand that UNDER ARKANSAS LAW, AN EQUINE ACTIVITY SPONSOR IS NOT LIABLE FOR AN INJURY TO, OR THE DEATH OF, A PARTICIPANT IN EQUINE ACTIVITIES RESULTING FROM THE INHERENT RISK OF EQUINE ACTIVITIES.

I, the undersigned, have read this waiver of liability in its entirety. I understand the terms of this release and have signed this release voluntarily and with full knowledge of the effects thereof.

Participant Signature _____ Date: _____

Signature of Parent/Guardian _____
(If participant is under 18 years of age)

POLICY OF CONFIDENTIALITY

I agree to respect and observe the privacy and confidentiality of the participants, volunteers and donors of Healing By Horseback, Inc. and will not discuss or disclose any sensitive information about any person or their family.

Participant Signature _____ Date: _____

Signature of Parent/Guardian _____
(If participant is under 18 years of age)

HEALING BY HORSEBACK

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

Name:_____

Please Print

In case of Emergency, contact: _____Phone(s): _____

Physician's Name: _____Phone: _____

Please indicate any allergies: _____

Please indicate any medical issues that may effect your/your child's participation during hippotherapy.

_____

_____

Date of last Tetanus shot: _____

CONSENT PLAN

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 emergency medical aid/treatment is required due to illness or injury during the process of receiving services, any participation on my part at Healing By Horseback, Inc., or while being on the property of Healing By Horseback, Inc., I authorize Healing By Horseback, Inc. 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.

Consent Signature _____ Date: _____

Signature of Parent/Guardian _____

(If participant is under 18 years of age)

~~~ OR ~~~

NON-CONSENT PLAN I do not give consent for emergency medical treatment/aid in the event of illness or injury during the process of receiving services, any participation on my part at Healing By Horseback, Inc., or while being on the property of Healing By Horseback, Inc.. In the event emergency treatment/aid is required, I wish the following procedures to take place:

_____

_____

Signature _____ Date: _____

Signature of Parent/Guardian_____

(If participant is under 18 years of age)