Horseplay Therapeutic Riding Center Volunteer Form
5949 Silveyville Rd., Dixon, CA 95620
(707)
horseplay.riding@gmail.com
horseplayriding.org

Name:_____ Date:_____

Date of Birth:_____ Phone: _____

E-mail:_____@_____

Emergency Contact: Name_____

Relationship_____Phone:_____

Recent medical tests:
(Consult your physician or local health department if you are not up to date with these shots/tests.)
Date of last tetanus shot:_____
Tuberculosis Test (circle one): positive negative Date: _____

Health History

Please describe your current health status: fitness, cardiac, respiratory, bone or joint function, recent hospitalizations/surgeries, or lifestyle changes.

_____

Allergies: _____

Medications: _____

I, the undersigned, as self, parent and/or legal guardian of _____ do hereby authorize and consent to any X-ray examination, anesthetic or surgical diagnosis rendered under the general or special supervision of any member of the medical staff and emergency room staff licensed under the provisions of the Medical Practice Act or a Dentist licensed under the Dental Practice Act and on the staff of any acute general hospital holding a current license to operate a hospital from the State of California Department of Public Health. It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care being required, but is given to provide authority and power to render care which the aforementioned physician in the exercise of his best judgment may deem advisable. It is understood that effort shall be made to contact parent(s) and/or legal guardians prior to treatment to the patient, but that any of the above treatment will not be withheld if the parent(s) and/or legal guardians cannot be reached.

Medical Insurance Company:

_____Policy #_____

Subscriber's Name_____Group #_____

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. I agree to keep all information about riders and volunteers confidential.

Signature: _____ Date: _____
(Signature of self, or if a minor, parent or legal guardian)

Photo Release (circle one)

I DO DO NOT
consent to and authorize the use and reproduction by Horseplay 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:_____
(Signature of self, or if a minor, parent or legal guardian)

Background Information

Have you ever been charged with or convicted of a crime (circle one)? YES NO

I, _____(volunteer/staff), authorize Horseplay Therapeutic Riding Center 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, including but not limited to convictions for crimes committed upon children. I understand that such access is for the purpose of considering my application as an employee/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:_____
(volunteer/staff)

CURRENT DRIVER'S LICENSE YES NO LICENSE NUMBER_____STATE_____

Do you have experience with horses (circle one)? YES NO If yes, please describe:_____

_____

RELEASE AND HOLD HARMLESS AGREEMENT

The program at the **HORSEPLAY THERAPEUTIC RIDING CENTER** provides therapeutic horseback riding for disabled children and adults. Volunteers and horses are carefully selected and trained and safety equipment is required for all riders since horseback riding is a risk exercise.

No student will be accepted for riding instruction and no volunteer accepted for service until this form has been **READ, UNDERSTOOD, COMPLETED AND SIGNED** by the parent(s) or guardian(s) of a minor, or if the student or volunteer is of legal age and sound mind, by the student or volunteer.

Although participation in the program is under strict supervision and every effort is made to avoid injury or accident, the undersigned acknowledges the inherent risks involved in riding and working around horses. This includes bodily injury from horseback riding or being in close proximity to horses. Among other risks, both horse and rider can be injured in normal use or in competition and schooling. In order to provide this valuable service, **NO LIABILITY** can be accepted by the **HORSEPLAY THERAPEUTIC RIDING CENTER, BLACK TIE ARABIANS, KRISTY FLYNN** or any of the organizations or persons connected with the above named facilities.

IN CONSIDERATION for the privilege of riding and/or working around horses at the **HORSEPLAY THERAPEUTIC RIDING CENTER,** the undersigned, as self, or as parent(s) or guardian(s) of the undersigned minor, jointly and severally, do hereby agree to release, hold harmless and indemnify the **HORSEPLAY THERAPEUTIC RIDING CENTER, BLACK TIE ARABIANS, AND KRISTY FLYNN,** their officers, directors, trustees, agents, employees, representatives, successors and assigns, from all manner of liability, loss, costs, claims, demands and damages of every kind and nature whatsoever, including but not limited to reasonable attorneys fees, which the undersigned or said minor may now or in the future have against the **HORSEPLAY THERAPEUTIC RIDING CENTER, BLACK TIE ARABIANS, KRISTY FLYNN**, their officers, directors, trustees, agents, employees, representatives, successors and assigns on account of any accident, damage, injury or illness, physical or mental condition, known or unknown, to the undersigned or said minor, or the treatment thereof, arising as a result of, or in any way connected to acts or incidents occurring at or relating to the **HORSEPLAY THERAPEUTIC RIDING CENTER, BLACK TIE ARABIANS, AND KRISTY FLYNN,** their officers, directors, trustees, agents, employees, representatives, successors or assigns, including but not limited to their negligence or gross negligence in rendering the services described above or in anyway incidental thereto.

Date_____Participant Name (Print)_____

Participant or Parent/Guardian Signature_____

Print Parent/Guardian Name (If Applicable)_____

Relationship to Participant_____

Address_____

City _____ State_____ Zip_____