Flying Free Therapeutic Riding Center, Inc.

Kirsten Robbie, CEO
P.O. Box 63
Woodstock, CT 06281
(959) 255-3405
Flyingfreetrc@gmail.com

Volunteer / Staff Information Form and Health History

General Information

Name: _____Date: _____

Address:

_____

Date of Birth: _____ Phone: (H) _____ (W) _____ Cell # _____

Email: _____

Employer/School: _____

Employer/School Address:

_____

Parent/Legal Guardian/Care-giver Name, Address, & Phone Number:

_____

_____

How did you learn about the program?

_____

Last Tetanus Shot: _____ Tuberculosis Test. + - Date: _____

(Consult your physician or local health department if you are not up to date with these shots/tests)

Health History:

Please describe your current health status, particularly regarding the physical/emotional demands of working in an equine-assisted program.

_____

_____

_____

_____

_____

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Allergies:

_____

_____

_____

Medications:

_____

_____

_____

_____

Check all areas in which you are interested:

☐ Horse Handling	☐ Sidewalking with a participant	☐ Barn / Grounds Maintenance
☐ Fundraising	☐ Public Relations	☐ Grant Writing
☐Vol. Recruitment	☐ Photography/Video	☐ Newsletter

I understand that the information provided above is accurate to the best of my knowledge. I have no reason why I should not participate in the Flying Free Therapeutic Riding Center, Inc. program.

Signature: _____ Date: _____

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Volunteer / Staff Information Form and Health History (pg 2)

Photo Release

I, _____(print name) ☐ DO ☐ DO NOT

consent to and authorize the use and reproduction by Flying Free Therapeutic Riding Center, Inc. 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: _____

Confidentiality Agreement

I, _____, understand that Flying Free Therapeutic Riding Center, Inc.
(First & Last Name)

is a therapeutic environment and maintains a strict confidentiality policy. This means that instructors will provide as much information about clients, volunteers, and staff necessary to maintain a safe and effective facility. By signing below, I agree to keep any privileged information including, but not limited to, personal and health information private and confidential.

Signature: _____ Date: _____

References

Please list names and phone numbers of two (2) people, which are not family members, who would be able to provide a character reference and / or professional reference regarding the special qualities you bring to our therapeutic riding setting. Thank you!

1.

_____

2.

_____

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Authorization for Emergency Medical Treatment Form

☐ Participant ☐ Staff ☐ Volunteer

Name: _____ DOB _____ Phone: _____

Address: _____

Physician's Name: _____ Preferred Medical Facility: _____

Health Insurance Co.:_____ Policy #:_____

Allergies to medications: _____

Current medications: _____

In the event of an emergency contact:

Name: _____ Relation: _____ Phone: _____

Name: _____ Relation: _____ Phone: _____

Name: _____ Relation: _____ Phone: _____

Consent Plan

In the event of an 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, and the above cannot be reached, I authorized Flying Free Therapeutic Riding Center, Inc. to :

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

This authorization includes x-rays, surgery, hospitalization, medication, and any treatment procedure deemed "lifesaving" by the physician. This provision will only be invoked if the person(s) above cannot be reached.

Date: _____ Consent Signature: _____

Client, Parent, or Legal Guardian

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Non-Consent Plan

I do not give my consent for emergency medical aid/treatment in the case of illness or injury during the process of receiving services or while being on the property of the agency.

- ☐ Parent or legal guardian will remain on site at all times during equine-assisted activities.
- ☐ In the event emergency treatment/aid is required, I wish the following procedure to take place:

_____

_____

_____

Date: _____ Non-Consent Signature: _____

Client, Parent, or Legal Guardian

Liability Release: _____ (name) would like to participate in Flying Free Therapeutic Riding Center, Inc. I acknowledge the risk and potential risks of horseback riding and related equine activities, including serious bodily harm. However, I feel that the possible benefits to myself / my child / my ward are greater than the risk assumed. I hereby, intending to be legally bound for myself, my heirs, and assigns, executors, and administrators, waive and release forever all claims for damages against Flying Free Therapeutic Riding Center, Inc., its Directors, Instructors, Therapists, Aides, Volunteers, and/or Employees for any and all injuries and /or losses I/my child/my ward may sustain while participating in the program from whatever cause including but not limited to the negligence of these released parties.

The undersigned acknowledges that he/she has read this form 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: _____

Client, Parent, or Legal Guardian