Hoofbeats Therapeutic Riding Center, Inc.

At the Virginia Horse Center
P.O. Box 979, Lexington, VA 24450
Ph: 540 464-3337 e-mail: hoofbeats@rockbridge.net
Website: www.hoof-beats.com

Professional Association of Therapeutic Horsemanship International
A Premier Accredited Member Operating Center

Volunteer/Staff Information, Releases, and Health History

Volunteer/Staff Name:_____ Date of Birth: _____ Age:_____

Address: _____ State: _____ Zip:_____ _____

Employer/School: _____

Work Address: _____ State: _____ Zip:_____

Phone: (H) _____ (W) _____ Cell_____

E-mail: _____

Parent/Legal Guardian Name: _____

Address:_____ State: _____ Zip:_____

Adult Caregiver (if any): Name: _____

Address:_____Phone:_____

Emergency Contact:_____Phone:_____

How did you learn about Hoofbeats:_____

SKILLS AND TYPES OF ASSISTANCE NEEDED AT HOOFBEATS

Hoofbeats has need of volunteer assistance in a variety of areas/capacities, including, but not limited to:

- Helping in lessons as a horse leader or sidewalker
- Assisting at special events (e.g. horse shows in which our riders participate)
- Horse care; stable help
- Office work
- Carpentry (facilities maintenance)
- Fundraising
- Art work (e.g. producing posters; props for games); costume design/construction
- Music (examples: sound system operation; helping select and record cd's for musical rides**)**

Please use the blanks below to describe your areas of interest, your particular talents, skills, or experience, and explain the ways in which you wish to contribute your time to Hoofbeats:

_____
_____
_____
_____
_____
_____
_____

Continued on next page

HEALTH HISTORY

Recent medical tests: Last Tetanus Shot (date): _____ Tuberculosis Test (date +-):_____

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

Please describe your current health status, particularly regarding the physical/emotional demands of working in a therapeutic riding program. Address fitness, cardiac, respiratory, bone or joint function, recent hospitalizations/surgeries, or lifestyle changes:

_____

_____

_____

Allergies (to Medications, etc.):_____

Current Medications:_____

PHOTO/VIDEO RELEASE

I consent to and authorize the use and reproduction by Hoofbeats Therapeutic Riding Center, Inc. of any and all photographs and any other digital, audiovisual, or videotape materials taken of me/my child/my ward for promotional printed material, internet website, educational activities, exhibitions or for any other use for the benefit of the program or TRAV or PATH.

Date_____ Signature_____
Print Name_____
Date_____ Signature_____
Print Name_____

(Volunteer / Staff; Parents/legal guardians must sign for children under 18 or wards of the court.)

BACKGROUND INFORMATION

Have you ever been convicted of a felony? ☐ No ☐ Yes

If yes, explain: _____

_____

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CONFIDENTIALITY POLICY/STATEMENT

1. Riders and their families, staff members, and volunteers have a right to privacy that gives them control over the dissemination of their medical or other sensitive information. **The therapeutic riding center shall preserve the right of confidentiality for all individuals in its program.**
2. **The staff shall keep confidential all medical, social, referral, personal and financial information regarding a person and his/her family. Any person who accidentally obtains such information must not disclose it to anyone without proper authorization.**
3. **Anyone who works or volunteers for, or provides services to, the therapeutic riding center is bound by the confidentiality policy, including but not limited to: full- and part-time staff, independent contractors, temporary employees, volunteers, and board members.**
4. **A person must be over the age of 18 to give consent for disclosure of medical or sensitive information. For anyone under the age of 18, only parent(s), legal guardian or other legal representatives may give consent for disclosure.** Adults with developmental disabilities are presumed legally competent to give or deny disclosure unless they have been adjudicated incompetent to make this type of health care decision. If a substitute decision maker has been appointed, written consent must be obtained from that individual.
5. **Disclosure of private or sensitive information will not be given out without a person's consent based on a *perceived* need to protect staff or anyone else from possible exposure through casual contact. EVERYONE should commonly practice infection control procedures with all riders and volunteers under the assumption that anyone could have HIV, hepatitis, or other blood-borne diseases.** Casual contact poses NO RISK of transmission of diseases such as HIV.
6. **Information will be disclosed to outside agencies or individuals only with the specific written consent of the rider or client (or volunteers due to a medical emergency).**
7. **Breach of this confidentiality policy may result in reprimand, loss of certain job/volunteer responsibilities, or termination of services/employment,** to be determined by the Program Director and/or Board of Directors based on the severity of the breach.

Other grounds for dismissal of volunteers or staff include, but are not limited to:
1) the use of drugs or alcohol on the grounds or at a Hoofbeats' event, 2) verbal or physical abuse or sexual harassment or other inappropriate behavior toward participants or other volunteers or staff members, 3) mistreatment of the horses or other animals at Hoofbeats, 4) the expression of vulgar language, "off-color" jokes, or disrespectful language, 5) frequent missed "work" times, without prior explanation, 6) abuse of phone privileges, 7) smoking in prohibited areas, 8) persistent failure to follow the rules or directions of the instructors or persistent disruption of riding lessons.

I have read, I understand, and I will follow the guidelines of the confidentiality policy, barn rules and policies and volunteer/staff conduct at Hoofbeats Therapeutic Riding Center, Inc. **(Parents/legal guardians must sign for children under 18 or wards of the court. Both parents/guardians must sign below if there is joint or shared custody.)**

Date_____Signature_____
Print Name_____

Date_____ Signature_____
Print Name_____

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HOOFBEATS THERAPEUTIC RIDING CENTER, INC. WAIVER AND NOTICE

☐ Student ☐ Volunteer ☐ Staff ☐ Board Member

I choose to participate in equestrian activities with Hoofbeats Therapeutic Riding Center, Inc., located at the Virginia Horse Center in Lexington, Virginia. And in order to do so, I agree to the following waiver of liability:

I recognize that there are risks inherent in participating in any equine activity, including: 1) the propensity of an equine to behave in dangerous ways which may result in injury or death of the participant; 2) the inability to predict an equine's reaction to sound, movements, objects, persons, or animals; and 3) certain hazards such as surface or subsurface conditions.

The undersigned, on behalf of himself/herself (hereinafter himself) and all members of his immediate family and household, and his and their heirs, executors, administrators as assigns, (collectively, the "PARTICIPANT") does hereby forever release and discharge HOOFBEATS THERAPEUTIC RIDING CENTER, INC. and its members thereof, of any and all claims, demands, causes of reaction and liability of any nature, which may arise from or in connection with my participation in equestrian activities at HOOFBEATS THERAPEUTIC RIDING CENTER, INC.

The PARTICIPANT hereby agrees to waive and not to assert or bring action at law or in equity or otherwise any claim, demand, cause of action, or liability against HOOFBEATS THERAPEUTIC RIDING CENTER, INC. or its members.

Signature:_____
(Must be 18 years of age or older, or parent/guardian must sign)

Print name as shown above:_____

Child's name (if applicable):_____

Date:_____

Address:_____
Street State Zip

Phone Number:_____ E-mail:_____

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AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT FORM

Check one: ☐ Participant ☐ Volunteer ☐ Staff

Name (of Participant, Volunteer or Staff Member):_____ Date of Birth:_____

Address:_____ Phone:_____

Preferred Medical Facility_____

Physician's Name:_____ Phone:_____

Health Insurance Co.:_____ Policy #_____

Emergency Contacts:

Name:_____ Relation:_____ Phone:_____

Name:_____ Relation:_____ Phone:_____

Allergies to Medications:_____

Current Medications:_____

In the event emergency medical aid/treatment is required due to illness or injury during the process of receiving services, volunteering, or while being on the property of the agency, I hereby authorize **Hoofbeats Therapeutic Riding Center, Inc.** to:

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

CONSENT PLAN (Parents/legal guardians must sign for children under 18 or for wards of the court)
This authorization includes x-ray, surgery, hospitalization, medication and any treatment procedure deemed "life-saving" by the physician. This provision will only be invoked if the person below is unable to be reached.

Date:_____ Consent Signature:_____

Print Name:_____

Phone:_____ Address:_____

NON-CONSENT PLAN
I do not give my consent for emergency medical treatment/aid in the case of illness or injury during the process of receiving services, volunteering, or while being on the property of the agency. In the event emergency aid/treatment is required, I wish the following procedures to take place (If you choose this plan, you must fill in some specifics for the aid which you will/will not allow)

_____

_____

_____

Date:_____ Non-Consent Signature:_____

Print Name:_____

Phone:_____ Address:_____