PATH INTERNATIONAL

Saddle Up Therapeutic Riding Stables
41455 20th St West
Palmdale, CA 93551
661-267-2730 FAX: 661-538-1639

Volunteer/Staff Information Form and Health History

General Information

Name: _____ Date: _____

Address: _____ City: _____ Zip: _____

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

Employer/School: _____

Address: _____

Parent/Legal Guardian/Caregiver Name: _____

Parent/Legal Guardian/Caregiver Address: _____

Parent/Legal Guardian/Caregiver Phone Number: _____

How did you learn about the program? _____

Recent medical tests: _____ 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. Address fitness, cardiac, respiratory, bone or joint function, recent hospitalizations/surgeries or lifestyle changes.

_____

_____

_____

_____

Allergies: _____

_____

Medications: _____

_____

_____

Check areas in which you are interested:

Program	Special Events	Administration	
☐ Horse Handling	☐ Horse Show	☐ Public Relations	☐ Photography/Video
☐ Sidewalking with a Student	☐ Fundraising	☐ Grant Writing	☐ Budget & Finance
☐ Stable Management	☐ Special Olympics	☐ Newsletter	☐ Future Planning
☐ Facility Repairs	☐ Trail Rides	☐ Volunteer Recruitment	

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.

Signature: _____ Date: _____

(volunteer/staff/caregiver; signed in presence of center staff)

Volunteer/Staff Information Form and Health History

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Name: _____

Address: _____

Phone: _____ Date of Birth: _____

Photo Release

I ❑ DO

❑ DO NOT

consent to and authorize the use and reproduction by _____
(PATH Intl. 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: _____

Background Information

Have you ever been charged with or convicted of a crime? Y N Please explain _____

_____

_____

I, _____(volunteer/staff), authorize _____ 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 or animals.

I understand that such access is for the purpose of considering my application as an employee/volunteer, and I expressly DO NOT authorize the PATH Intl. 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 Y N LICENSE NUMBER _____ STATE _____

Confidentiality Agreement

I understand that all information (written and verbal) about participants at this PATH Intl. center is confi dential and will not be shared with anyone without the expressed written consent of the participant and his/her parent/guardian in the case of a minor.

Signature: _____ Date: _____
(volunteer/staff)

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Authorization for Emergency Medical Treatment Form

o Participant o Staff o Volunteer

Name: _____ DOB: _____ Phone: _____
Address: _____
Physician's Name: _____ Preferred Medical Facility: _____
Health Insurance Company: _____ 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 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,
I authorize _____ to:
(Center's Name)

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-ray, surgery, hospitalization, medication and any treatment procedure deemed "life saving" by the physician> This provision will only be invoked if the person(s) above is unable to be reached

Date: _____ Consent Signature: _____
Client, Parent or Legal Guardian
Signed in presence of center staff

Saddle Up Therapeutic Riding Stable
41455 20th Street West Palmdale, CA 93551
661-267-2730 661-538-1639 Fax
Federal Tax ID # 95-4755466

CONFIDENTIALITY POLICY

1. Saddle Up Therapeutic Riding Stables (Saddle Up) and its staff members understand the importance of preserving the right of confidentiality for all individuals in its program.

2. Staff members include, but are not limited to, full-time and part-time employees, board members, independent contractors, temporary employees, and volunteers.

3. Saddle Up and its staff members shall keep confidential and refuse to disclose any and all medical, social, referral, personal and financial information, regarding a rider and his/her family, to any person or agency which is not related to Saddle Up or its programs.

4. The disclosure of any medical, social, referral, personal or financial information to outside individuals or agencies is permitted only when the rider, his/her parents, or his/her guardian provide specific written consent.

5. Any failure to comply with this Confidentiality Policy will result in personal and professional penalties, including but not limited to, reprimand, loss of certain job responsibilities and termination.

6. I understand and will observe the Confidentiality Policy of Saddle Up Therapeutic Riding Stables.

_____ _____

Signature Date

_____ _____

Witness Witness Title

Saddle Up Therapeutic Riding Stables

Horseback Riding Agreement and Release of Liability Form

Volunteer Name:_____Date of Birth_____

Address_____City_____State_____

Zip_____Telephone_____Alternate phone_____

Liability Release: I understand that this is a high-risk sport and I am participating at my own risk. I hereby assume this risk and further do hereby release and hold harmless the owners of the property, and its agents, employees, volunteers, and the host of this "equestrian activity" from all liability for negligence resulting in accidents, damage, injury or illness to myself and to my property, including the horse or horses which I will ride at this facility.

Release, Assumption of Risk, Waiver and Indemnification

********This document waives important legal rights. Read it carefully before signing.********

I AGREE in consideration for my participation in this "equestrian activity" at Saddle Up Therapeutic Riding Stables to the following:

I AGREE that I choose to participate voluntarily in the "equestrian activity" with a horse, as a rider, lessee owner, agent, coach, trainer, or as parent or guardian of a junior rider, I am fully aware and acknowledge that horse sports involve inherent dangerous risks of accident, loss, and serious bodily injury including but not limited to broken bones, head injuries, trauma, pain, suffering, or death ("Harm").

I AGREE to release the "equestrian activity", the property owners, and its agents, employees, volunteers, and the host of this "equestrian activity" from all claims for money damages or otherwise for any Harm to me or a horse and for any Harm caused by me or a horse to others, even if the Harm resulted, directly or indirectly, from the negligence of the "equestrian activity."

I AGREE to expressly assume all risks of Harm to me or a horse, including Harm resulting from the negligence of the "equestrian activity", the property owners, and its agents, employees, volunteers, and the host of this "equestrian activity."

I AGREE to indemnify (that is, to pay any losses, damages, or costs incurred by) the "equestrian activity", the property owners, and its agents, employees, volunteers, the host of this "equestrian activity", and to hold them harmless with respect to claims for Harm to me or a horse, and for claims made by others for any Harm caused by me or a horse at this facility.

I am entitled to wear protective equipment without penalty, and I acknowledge that the "equestrian activity", the property owners, and its agents, employees, volunteers, and the host

Saddle Up Therapeutic Riding Stables

Horseback Riding Agreement and Release of Liability Form

of the "equestrian activity" requires me to do so while WARNING that no protective equipment can guard against all injuries.

If I am a parent or guardian of a minor rider, I consent to the child's participation and AGREE to all of the above provisions and AGREE to assume all of the obligations of this Release on the child's behalf.

I AGREE that the "equestrian activity" as used above includes all the property owners, its agents, employees, volunteers, and the host of this "equestrian activity."

BY SIGNING BELOW, I UNDERSTAND AND AGREE to be bound by all applicable terms and provisions of this riding agreement.

Volunteer's Signature_____Date_____

Parent/Guardian Signature_____Date_____

Parent/Guardian Signature required if rider is under age 18