



RIDING  
EQUINES TO  
ACHIEVE  
CONFIDENCE &  
HEALTH

## Volunteer Application and Health History

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Date: \_\_\_\_\_

Home Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

**Preferred method to contact you:**     *Phone*     *Text message*     *Email*

Parent/Legal Guardian Name (if under 18) \_\_\_\_\_

How did you learn about REACH? \_\_\_\_\_

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

\_\_\_\_\_

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

If yes, explain: \_\_\_\_\_

Please place a check by the description that best matches your horsemanship skills:

New or very little knowledge     Beginner     Intermediate     Advanced     Instructor or Clinician

### Health History

Current Tetanus Shot:  Yes  No

Working in a therapeutic riding center can be physically demanding. 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: \_\_\_\_\_

Check which areas you are interested in:

<input type="checkbox"/> Horse Leader	<input type="checkbox"/> Cow Hands	<input type="checkbox"/> Exercising Horses	<input type="checkbox"/> Photography/Video
<input type="checkbox"/> Side Walker	<input type="checkbox"/> Top Hands	<input type="checkbox"/> Fund raising/Grants	<input type="checkbox"/> Budget/Finance
<input type="checkbox"/> Tack Team	<input type="checkbox"/> Reception/Office	<input type="checkbox"/> Computers/Technology	<input type="checkbox"/> Other _____
<input type="checkbox"/> Barn Buddies	<input type="checkbox"/> Schooling Horses	<input type="checkbox"/> 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.

I have received, read and understand the REACH TRC Volunteer Handbook.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

If under 18 years, Parent/Guardian Signature \_\_\_\_\_



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## 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:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Action/Disposition \_\_\_\_\_

\_\_\_\_\_

I understand that REACH Therapeutic Riding Center 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 center'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 R.E.A.C.H. 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: \_\_\_\_\_

If under 18 years, Parent/Guardian Signature \_\_\_\_\_



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## Volunteer 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 REACH Therapeutic Riding Center (RTRC) 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 RTRC, its board of directors, trustees, agents, instructors, therapists, employees, representatives, volunteers, owners of property on which RTRC 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 RTRC, its board of directors, trustees, agents, instructors, therapists, aids, employees, representatives, volunteers, owners of property on which RTRC operates, successors or assigns.

### WARNING

**I understand that under Texas Equine Liability Act (Chapter 87, Civil Practice and Remedies Code), an equine professional is not liable for an injury to or the death of a participant in equine activities resulting from the inherent risks 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.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

If under 18 years, Parent/Guardian Signature \_\_\_\_\_

## Policy of Confidentiality

I agree to respect and observe privacy and confidentiality of the participants, volunteers and donors of REACH Therapeutic Riding Center and not discuss or disclose any sensitive information about any person or their family.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

If under 18 years, Parent/Guardian Signature \_\_\_\_\_



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## Authorization for Emergency Medical Treatment Form

Name: \_\_\_\_\_

Physician's Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

In the event of an emergency, contact:

Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Phone: \_\_\_\_\_

In the event emergency medical aid or 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 REACH Therapeutic Riding Center to:

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

### Consent Plan

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.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

If under 18 years, Parent/Guardian Signature \_\_\_\_\_

### Non-Consent Plan

I do not give my consent for emergency medical treatment or aid in the case of illness or injury during the process of receiving services or while being on the property of the agency. In the event emergency treatment/aid is required, I wish the following procedures to take place:

\_\_\_\_\_  
\_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

If under 18 years, Parent/Guardian Signature \_\_\_\_\_