



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 _____