A NARHA CENTER MEMBER PROGRAM

VOLUNTEER INFORMATION FORM

NAME:______________________________ EMAIL ADDRESS:______________________________

HOME PHONE:________________ CELL PHONE:__________________ OTHER PHONE:______________

ADDRESS:____

DATE OF BIRTH:______________ NAME OF PARENT OR GUARDIAN:_________________________

EMPLOYER/SCHOOL: ____

How did you learn about Angels on Horseback?____________________________________

Check the areas you are interested in:

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

Have you ever been charged with or convicted of a crime? ☐ No ☐ Yes. Please explain:________________

____

Driver's License # and State Where Issued:_____________________________________

AUTHORIZATION FOR BACKGROUND CHECK

INITIALS: _________ I hereby authorize Angels on Horseback 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 a volunteer and that I expressly DO NOT authorize the NARHA center, its directors, officers, employees, or other volunteers to disseminate this information in any way to any other individual, group, agency, organization or corporation.

CONFIDENTIALITY NOTICE

INITIALS: _________ I understand that all information (written or verbal) about participation at this NARHA center is confidential and will not be shared with anyone without the expressed written consent of the participant and their parent/guardian in the case of a minor.

PHOTO RELEASE

INITIALS: _________ I ☐**do** ☐**do not** consent to and authorize the use and reproduction by Angels on Horseback of any and all photographs and any other audio/visual materials taken of me for promotional material, educational, exhibitions or for any other use for the benefit of the center.

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

Signature:___________________________________ **Date:**_______________________
Parent or Legal Guardian (*if Volunteer is under 21*)

RETURN SIGNED DOCUMENT TO: Karen Davis, 100 Fawn Court, #20137, Jasper, GA 30143

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EMERGENCY MEDICAL TREATMENT AUTHORIZATION FORM

NAME:______________________________ D.O.B.: ______________

ADDRESS:____

PHYSICIAN'S NAME:______________ PREFERRED HOSPITAL: ______________

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

____

Date of last tetanus shot:______________ Date of last tuberculosis test: ______________

Allergies:____

Current medications:______________________________________

In the event of an emergency, contact:

Name: ______________________ Relation:__________ Phone:__________

Name: ______________________ Relation:__________ Phone:__________

*** * * HEALTH INSURANCE INFORMATION REQUIRED * * ***

INSURANCE COMPANY NAME:______________________________

POLICY #:______________ **PHONE NUMBER:**______________

CONSENT PLAN. In the event emergency medical aid/treatment is required to due to illness or injury during the process of receiving services or while being on the property of the agency, I authorize Angels on Horseback to:

- ☑ Secure and retain medical treatment and transportation if needed.
- ☑ Release client records upon request to 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: ______________________

Signed by Volunteer (or Parent/Guardian if under 21)

- OR -

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 or while being on the property of Angels on Horseback.

- ☑ 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:______________

____

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:______________ Non-Consent Signature: ______________________

Signed by Volunteer (or Parent/Guardian if under 21)

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HOLD HARMLESS AND INDEMNITY AGREEMENT

--WARNING--

Under Georgia law, an equine activity sponsor or 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, pursuant to Chapter 12 of Title 4 of the Official Code of Georgia Annotated.

This Hold Harmless and Indemnity Agreement ("Agreement") is made this ______ day of _________________, 20_____ between ____ ("Participant") and ANGELS ON HORSEBACK, INC., Therapeutic Riding Program and staff shall continue in full force and effect until revoked in writing.

Participant and Participant's Parent or Guardian understands and acknowledges that there are inherent risks in being around horses and participating in equine activities. These risks may result in property damage and/or physical injury, including death.

Participant hereby releases and agrees to hold harmless, Angels On Horseback, it's owners, board, instructors, volunteers, fieldhands, and the property owners from any and all liability arising from any accident, injury or loss which may occur while on farm property with any horse, animal or other circumstance which might present itself and Participant might be involved.

This Agreement shall be construed under the laws of the State of Georgia.

Participant, being of legal age, (21) or parent or guardian of participant below legal age, acknowledges that he/she has read the above Agreement, has had an opportunity to ask questions and voluntarily agrees to the terms of this Agreement.

_______________________________________ Printed Name of Participant

_______________________________________ Signature of Participant

IF PARTICIPANT IS BELOW THE AGE OF 21, A PARENT OR LEGAL GUARDIAN MUST SIGN BELOW:

_______________________________________ Printed Name of Parent/Guardian

_______________________________________ Signature of Parent/Guardian

_______________________________________ Leslie B. Elliott for Angels on Horseback, Inc.

RETURN SIGNED DOCUMENT TO: Karen Davis, 100 Fawn Court, #20137, Jasper, GA 30143