Healing Horse Therapy Center

1752 C Road, Loxahatchee Groves, FL 33470
561-914-1718 info@healinghorse.org

PATH INTERNATIONAL
Professional Association of Therapeutic Horsemanship International
— MEMBER —

Volunteer/Staff Information & Health History

General Information

Name: _____ Date: _____

Address: _____

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

Employer/School: _____

Address: _____

Parent/Legal Guardian/Caregiver Name/Address/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 hospitalization/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, Parent or Legal Guardian

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Volunteer/Staff Information & Health History Continued

Name: _____

Address: _____

Phone: _____ Date of Birth: _____

Photo Release

I ❑ DO

❑ DO NOT consent to and authorize the use and reproduction by Healing Horse Therapy 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: _____

Volunteer/Staff, Parent or Legal Guardian

Background Information

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

_____

_____

I, _____(volunteer/staff), authorize Healing Horse Therapy Center 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 confidential 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

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 authorized Healing Horse Therapy Center to:

1. Secure and retain medial 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-rays, 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: _____
Volunteer/Staff. Parent or Legal Guardian

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 the agency.

- 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:

_____

Date: _____ Non-Consent Signature: _____
Volunteer/Staff. Parent or Legal Guardian

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Release of Liability

I, _____ the undersigned, adult, client, or parent or guardian of_____ , a minor, would like to participate at Healing Horse Therapy Center.

I acknowledge the risks and potential for risks of horseback riding. I understand that I/my/son/daughter/ward, will be working and around horses, as well, as riding horses of Healing Horse Therapy Center, Inc. However, I feel that the possible benefits to myself/son//daughter/ward are greater than the risk assumed. I, the undersigned client and/or parent or guardian, hereby, intending to be legally bound, for myself, my heirs and assigns, executors or administrator, waive and forever release, acquit, discharge and hold harmless all claims for damages against Healing Horse Therapy Center, its board of directors, trustees, agents, instructors, therapists, employees, representatives, volunteers, owners of property on which Healing Horse Therapy Center operates, successors or assigns.

WARNING

Under Florida Equine Activities statutes (Chapter 773), 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.

I HAVE FULLY READ AND FULLY UNDERSTAND THE FOREGOING LIABILITY RELEASE.

Signature: _____ Date: _____
Volunteer/Staff, Parent or Legal Guardian

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Volunteers must initial once per year to verify that the information is current.

~ Any changes will require a new form ~

Form Reviewed: _____ /2013 _____ /2014 _____ /2015 _____ /2016 _____ /2017