Reining Strength Therapeutic Horsemanship
7126 FM 359 Rd
Richmond, TX 77406
(832) 451-6874 office
1-844-272-3087 FAX
www.reiningstrength.org

Volunteer/Staff Information Form and Health History 2019

General Information

Name:_____ Email:_____

Street Address:_____ City:_____ State:_____ Zip:_____

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

Parent/Legal Guardian: _____

Street Address:_____ City:_____ State:_____ Zip:_____

_____

How did you learn about the program? _____

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**: _____

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Volunteer/Staff Information Form and Health History Cont.

Background Information

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

_____

_____

I,_____(volunteer/staff), authorize Reining Strength Therapeutic Horsemanship 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 Reining Strength, 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)

The Volunteer Coordinator will contact you to obtain your Social Security Number for the background check. For your privacy your SSN will be used only to complete the background check and will be destroyed afterwards.

Availability:

Please provide your preferred method of contact as well as your availability on the provided space.

Preferred Contact: Cell Phone Home Phone Email

Availability (Days and times):

_____
_____
_____
_____
_____

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Authorization for Emergency Medical Treatment 2019

Volunteer's Complete Legal Name:		
Date of Birth:		
Home Phone: ( )	Cell Phone: ( )	Work Phone: ( )
Physician's Name:	Medical Office/Facility:	
Health Insurance Company:		
Allergies (medications/food/other):		
Current Medications:		

Emergency Contact Information

Name:	Relationship:	
Home Phone: ( )	Cell Phone: ( )	Work Phone: ( )
Name:	Relationship:	
Home Phone: ( )	Cell Phone: ( )	Work Phone: ( )
Name:	Relationship:	
Home Phone: ( )	Cell Phone: ( )	Work Phone: ( )

Medical Treatment Consent

In the event that emergency medical aid/treatment is required due to illness or injury during the process of receiving services, or while being on Reining Strength Therapeutic Horsemanship property, I authorize Reining Strength Therapeutic Horsemanship, to:

1. Secure and retain medical treatment and transportation if needed
2. Release client/participant's 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 physicians. This provision will only be invoked if none of the Emergency Contacts listed above can be reached.

Printed name of Volunteer:	Date:

➡ Volunteer's Signature (or Signature of Parent/Guardian if under the age of 18):

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Orientation and Confidentiality

I have attended an orientation at Reining Strength Therapeutic Horsemanship (RSTH) and have an understanding of the information provided, have demonstrated the procedures pertaining to volunteering, and have received and read or will read a copy of the RSTH volunteer manual. I also have been made aware of RSTH's confidentiality policy and understand that the any information that I have become privy to about a client during my time as a volunteer shall remain confidential. The consequences of violating RSTH's confidentiality and privacy policy may include removal from the program.

Printed name of volunteer:	Date:

➡ Volunteer's Signature:

Photo Release 2019

Volunteer's Name:

☐ I Consent to and authorize
☐ I do NOT consent to

the use and reproduction by *Reining Strength Therapeutic Horsemanship* of any and all photographs and any other audio/visual materials taken of me or my family member for promotional material, educational activities, exhibitions, or for any other use for the benefit of the program or PATH Int'l.

➡ Volunteer's Signature (or Signature of Parent/Guardian if under the age of 18):	Date:

Liability Release

I,_____, the undersigned adult as volunteer, or parent or guardian of _____, a minor, would like to participate as a volunteer at *Reining Strength Therapeutic Horsemanship*.

I acknowledge the risks and potential for risks of equine activities. I understand that I/my son/daughter/ward, will be working with and around horses, as well as, riding horses at *Reining Strength Therapeutic Horsemanship*. 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 Reining Strength Therapeutic Horsemanship, its board of directors, trustees, agents, instructors, therapists, employees, representatives, volunteers, owners of property on which Reining Strength Therapeutic Horsemanship operates, successors or assigns on account of any personal injuries and/or personal damages known or unknown, or in any way growing out of, the acts of Reining Strength Therapeutic Horsemanship, its board of directors, trustees, agents, instructors, therapists, employees, representatives, volunteers, owners of the property on which Reining Strength Therapeutic Horsemanship operates, successors or assigns.

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

➡ Volunteer's Signature (or Signature of Parent/Guardian if under the age of 18):	Date: