Chariot Riders Inc. Ocean County
A therapeutic riding academy for everyone!

3170 Chariot Court
Manchester, NJ 08759
(732) 657-2710

Volunteer/Staff Information Form and Health History

General information

Name: _____ Date: _____

Address: _____

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

Employer/School: _____

Address: _____

Parent/Legal Guardian Name and Address: _____

_____

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 hospitalizations/surgeries, or lifestyle changes.

_____

_____

_____

_____

_____

_____

_____

Allergies: _____

_____

Medications: _____

_____

_____

Check which areas you are interested in:

Program
- ❑ Horse Handling
- ❑ Sidewalking with a Student
- ❑ Stable Management
- ❑ Facility Repairs

Special Events
- ❑ Horse Show
- ❑ Fundraising
- ❑ Special Olympics
- ❑ Trail Rides

Administration
- ❑ Public Relations
- ❑ Grant Writing
- ❑ Newsletter
- ❑ Volunteer Recruitment
- ❑ Photography/Video
- ❑ Budget & Finance
- ❑ Future Planning

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; signed in presence of center staff)

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Volunteer/Staff Information Form and Health History -

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Name: _____

Address: _____

Phone: _____ Date of Birth: _____

Photo Release

I ❑ DO
❑ DO NOT

consent to and authorize the use and reproduction by _____ 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 center.

Signature: _____ Date: _____

Background Information

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

_____

_____

I, _____ (volunteer/staff), authorize _____ 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 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.

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 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.

Signature: _____ Date: _____
(volunteer/staff(NARHA center)

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Authorization for Emergency Medical Treatment Form

❑ Participant ❑ Staff ❑ Volunteer

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: _____

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 authorize _____ to:
(Center's Name)

1. Secure and retain medical treatment and transportation if needed.
2. Release client 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.

Date: _____ Consent Signature: _____
Client, Parent or Legal Guardian
Signed in presence of center staff

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: _____ Consent Signature: _____
Client, Parent or Legal Guardian
Signed in presence of center staff

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Client Liability Release

I/my son/my daughter/my ward would like to participate in the **Chariot Riders Inc.** program(s). I acknowledge the risks and potential for risks of engaging in horseback riding activities as well as activities in close proximity to horses. However, I feel that the possible benefits to me/my son/my daughter/my ward are greater than the risks assumed. I hereby, intending to be legally bound, for myself, my heirs and assigns, executors and/or administrators, waive and release forever all claims for damages against **Chariot Riders Inc.**, its Board of Directors, Instructors, Therapists, Aides, Volunteers, and/or Employees for any and all injuries and/or losses that I/my son/my daughter/my ward may sustain while participating in activities at **Chariot Riders Inc**.

Print name: _____ Date: _____
Caregiver/Client/Legal guardian consent signature: _____

Photo Release

I hereby: (choose one)

❑ **consent** to and authorize or ❑ **do not consent** to or authorize

the use and reproduction by **Chariot Riders Inc.** of any and all photographs and any other audio-visual materials taken of me for promotional material, educational activities, and exhibitions or for any other use for the benefit of the program.

Print name: _____ Date: _____
Caregiver/Client/Legal guardian consent signature: _____

Volunteer Availability

Please indicate when you are available to volunteer at Chariot Riders.

Day	**Time** (am or pm)
Monday	_____
Tuesday	
Wednesday	_____
Thursday	_____
Friday	_____
Saturday	_____

Comments _____

_____

_____

Other _____

_____

_____