SPECIAL TROOPERS ADAPTIVE RIDING SCHOOL
33148 K22—Sioux City, IA 51108—www.scstars.org—P: 712.239.5042—F: 712.224.3471

RETURNING VOLUNTEER FORM

Please print legibly

NAME: _____ Age: _____ DOB: _____ Height: _____

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

Primary Phone: _____ Secondary Phone: _____

Email: _____ Best way to contact you: Email ☐ Phone ☐ or Text ☐

Parent/Guardian Name (if under 18): _____ Phone: _____

Address (if different than above): _____

T-shirt Size: Youth ☐ _____ Adult ☐ _____

Do you know anyone else that would be interested in volunteering with our program? _____

_____

Additional Information you would like to note: _____

_____

_____

_____

VOLUNTEER PREFERENCES & INTERESTS

I would like to help in the following other areas. Please check all that apply!

- ☐ Leader for TR Classes
- ☐ Sidewalker for TR Classes
- ☐ Sub for TR Classes
- ☐ Pitchfork Cookout
- ☐ Denim & Dreams
- ☐ Weekly Barn Cleaning
- ☐ Barn & Grounds Maintenance
- ☐ Horse Camp

Signature (Self, Parent, or Guardian): _____ Date: _____

Printed Name: _____ Relationship to Participant: _____

***If under 18 years of age, Parent/Guardian MUST sign**

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AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

In the event emergency medical aid/treatment is required due to illness or injury while receiving services, being on property, or participating in an authorized activity of STARS, Inc., I authorize Special Troopers Adaptive Riding School (STARS, Inc.) to:

1. Secure and retain medical treatment and transportation as needed.
2. Release participant records upon request to the authorized individual or agency involved in the medical emergency treatment.

VOLUNTEER'S NAME: _____ Age: _____ DOB: _____

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

Primary Phone: _____ Secondary Phone: _____

Parent/Guardian Name (if under 18): _____ Phone: _____

In the event of an emergency, please list who should be contacted:

Contact Name: _____ Relationship: _____ Phone: _____

Contact Name: _____ Relationship: _____ Phone: _____

Physician's Name: _____

Preferred Medical Facility: _____

Health Insurance Company: _____ Policy #: _____

CRITICAL HEALTH INFORMATION

(Ex: DNR, Food Allergies, Medication Allergies, etc.) ☐ None ☐ Yes - Please note below

_____

_____

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 below is unable to be reached.

Signature (Self, Parent, or Guardian): _____ Date: _____

Printed Name: _____ Relationship to Participant: _____

If under 18 years of age, Parent/Guardian MUST sign

NON-CONSENT

*I do **NOT** give my consent for emergency medical treatment/aid in the case of illness or injury. Please note that by signing the non-consent this may exclude you from participating in programming at STARS Inc.*

Signature (Self, Parent, or Guardian): _____ Date: _____

Printed Name: _____ Relationship to Participant: _____

If under 18 years of age, Parent/Guardian MUST sign