4STEPS Therapeutic Riding Program

4STEPS is a 501c3 charitable organization and a Premier Accredited Center of the Professional Association of Therapeutic Riding Intl. (PATHIntl.)
5367A Sixty Foot Road Parsonsburg Maryland 21849
www.4stepstrp.org 410-835-8814 giddyup4steps@aol.com

Volunteer/Staff Information Form and Health History

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GENERAL INFORMATION

Name_____Date_____
Address_____
Employer/School_____email_____
Date of Birth_____ Phone_____Cell_____Work_____
Parent/Guardian/Caregiver Name and Address_____
_____
How did you learn about the program? _____
Recent medical tests: last Tetanus shot: _____ Tuberculosis + -- Date _____
Consult your physician or local health department if you are up to date with these shots/tests

HEALTH HISTORY

Please describe your current health status, particularly regarding the physical/emotional demands of working in a therapeutic riding 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	**Special Events**	**Administration**	
Horse handling	Horse show	Public relations	Photography & Video
Sidewalking	Fundraising	Grant writing	Budget & Finance
Stable management	Special Olympics	Newsletter	Future Planning
Facility repairs	Trail rides	Volunteer recruitment	

Describe your abilities/experience in riding and working with horses
_____
_____
Describe your abilities/experience in working with children or adults, with or without disabilities.
_____
_____
Will this volunteer experience fulfill requirements for school/other? If yes, explain.
_____
_____

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 4STEPS TRP program.

Signature _____ Date _____
Volunteer/staff signed in presence of center's staff

*Reviewed by*_____*Date*_____ *Reviewed by*_____*Date*_____

The information on this form IS reviewed and updated annually. If you need to update this from during the year please notify the program director.

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Name_____Date_____
Address_____
Phone: _____cell_____email _____Date of Birth _____

PHOTO RELEASE

I DO ☐
I DO NOT ☐

consent to and authorize the use and reproduction by 4STEPS TRP 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_____

LIABILITY RELEASE

In consideration of 4STEPS TRP allowing my participation in this activity I agree to hold harmless and release 4STEPS TRP from legal liability except in the event of 4STEPS TRP gross and willful negligence, I shall bring no claims, demands, actions and causes of action, and/or litigation, against 4STEPS TRP for any economic and non-economic losses due to bodily injury, death, property damage, sustained by me in relation to the premises and operations of 4STEPS TRP, to include while learning about riding, or while riding, handling, or otherwise being near horses owned by or in the care, custody and control of 4STEPS TRP. Having received the Volunteers Manual, I UNDERSTAND THE ASSUMPTION OF RISK.

Signature _____Date _____
Volunteer/staff
Signature of parent/guardian/caregiver (if under 17)
_____Date _____

BACKGROUND INFORMATION

Have you ever been convicted of a crime? Y N please explain _____
_____

I, _____(volunteer/staff) authorize 4STEPS TRP to receive information from any law enforcement agency including police and sheriff's department, of this state or any other state or federal government, pertaining to any convictions I may have had including convictions for crimes committed upon children. I understand that such access is for the purpose of considering my application as a volunteer and that I expressly DO NOT authorize 4STEPS TRP to disseminate this information in any way to any other individual, group, agency, organization, or corporation.

Signature _____Date_____

CURRENT DRIVER'S LICENSE Y N License Number _____STATE_____

CONFIDENTIALITY AGREEMENT

I understand that all information (written and verbal) about participants at 4STEPS TRP is confidential and will not be shared with anyone without the express written consent of the participant and their parent/guardian/caregiver in the case of a minor.

Signature_____ Date _____
Volunteer/staff

*Reviewed by*_____*Date*_____ *Reviewed by*_____*Date*_____

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Authorization for Emergency Medical Treatment Form

____ Participant ____ Staff ____ Volunteer

Name: _____ DOB: _____ Phone: _____

Address: _____

Physician's Name: _____Medical Facility: _____

Health Insurance Company:___ _____ Policy #:_____

Allergies to medications_____

Current medications: _____

In the event of an emergency, contact:

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 4STEPS TRP to: 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 Name (please print)_____

Consent Signature _____
Client, Parent, Legal Guardian, or Caregiver 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:_____ Non-Consent Name (please print)_____

Non-Consent Signature _____
Client, Parent, Legal Guardian, or Caregiver Signed in presence of center staff

Take this form to your local Emergency Room to assure that all pertinent information is present

*Reviewed by*_____*Date*_____

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