



# H.O.R.S.E. Therapies, Inc

Helping Others Rehabilitate through the Service of Equines

## Volunteer Application

We are so excited that you have decided to volunteer with H.O.R.S.E. Therapies, Inc.. Our program relies heavily on the participation of volunteers, we can't perform our adaptive riding sessions without you!

### H.O.R.S.E. Therapies, Inc. General Information:

Email: [info@jaxhorsetherapies.org](mailto:info@jaxhorsetherapies.org)

Phone Number: (904) 255-4228

Address: 13611 Normandy Blvd, Jacksonville FL 32221

### Volunteer General Information:

Date of application: \_\_\_\_\_

Name (Please include first, middle & last): \_\_\_\_\_

Phone: \_\_\_\_\_ Text: Y N

Email Address: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Employer/School: \_\_\_\_\_ Are you Retired? Y N

Parent/Legal Guardian Name (if minor): \_\_\_\_\_ Phone: \_\_\_\_\_ How

did you hear about H.O.R.S.E. Therapies, Inc.?

Can you walk for 40 minutes and jog for short distances? Y N

Comments: \_\_\_\_\_

Given a chance to change sides frequently, can you hold your arm at shoulder height and support a modest weight?

Y N

Comments: \_\_\_\_\_

What experience (helpful but not necessary) do you have with horses?

Do you have previous experience with special needs? Y N

Comments: \_\_\_\_\_

I am interested in volunteering in the following areas:

_____ Adaptive Riding Sessions (See handbook)	_____ Program Ambassador
_____ Barn Chores	_____ Special Events
_____ Facility Maintenance	_____ Fundraising/ Grant writing
_____ Cleaning & organizing tack & equipment	_____ Photography/ Videography

# H.O.R.S.E. Therapies, Inc

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## H.O.R.S.E. Therapies, Inc. Medical Release Form

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 the property of the agency, I authorize H.O.R.S.E. Therapies, Inc. and/or agents acting on its behalf to:

- 1) Secure and retain medical treatment and transportation if needed.
- 2) Release client records upon request to authorized individual or agency in the medical emergency treatment.

DOB: \_\_\_\_\_

Last tetanus shot: \_\_\_\_\_

Physician's name: \_\_\_\_\_ Preferred Medical Facility: \_\_\_\_\_

Health Insurance: \_\_\_\_\_ Policy #: \_\_\_\_\_

Allergies to medications: \_\_\_\_\_

Current medications: \_\_\_\_\_

Please describe your current health status, particularly regarding the physical/emotional demands of working in an adaptive riding program. Please address fitness, cardiac, respiratory, bone or joint function, recent hospitalizations/surgeries or lifestyle changes:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

In the event of an emergency, contact:

Name: \_\_\_\_\_ Cell: \_\_\_\_\_ Other: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Cell: \_\_\_\_\_ Other: \_\_\_\_\_ Relationship: \_\_\_\_\_

### Consent Plan

This authorization includes x-rays, surgery, hospitalization, medication, and any treatment procedure deemed "life-saving" by physician. This provision will only be invoked if the person below is unable to be reached.

Date: \_\_\_\_\_ Consent Signature: \_\_\_\_\_

### 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. In the event emergency treatment/aid is required I wish the following procedures to take place:

\_\_\_\_\_  
\_\_\_\_\_

Date: \_\_\_\_\_ Non-Consent Signature: \_\_\_\_\_

# H.O.R.S.E. Therapies, Inc

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## BACKGROUND INFORMATION

H.O.R.S.E. Therapies, Inc. requires background checks for all volunteers at/over the age of 18. This will be at the cost of the applicant and required before the applicant may engage in any H.O.R.S.E. Therapies, Inc. activities. Information regarding this process will be provided by our volunteer coordinator upon the receipt of the volunteer application.

Have you ever been charged with or convicted of a crime, including sex-related or child-abuse related offenses?

Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, please explain:

\_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Social Security #: \_\_\_\_\_

DOB: \_\_\_\_\_

I hereby authorize H.O.R.S.E. Therapies, Inc. to receive information from any law enforcement agency, including police 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. I understand that such access is for the purpose of considering my application as an volunteer, and I expressly DO NOT authorize the operating 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: \_\_\_\_\_

## CONFIDENTIALITY AGREEMENT

I understand that any personal or identifying information that learn about clients through my association with H.O.R.S.E. Therapies, inc. will remain confidential. I agree to refrain from discussing such details as clients' names, specific diagnosis, unusual behavior, etc., with anyone outside the program or with another program member in a public circumstance where I might be overheard. I understand the necessity of preserving our clients' privacy and anonymity and will abide by this agreement.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## PHOTO/ MEDIA RELEASE

I authorize the use and reproduction by H.O.R.S.E. Therapies, Inc. of any and all photographs and any other audiovisual and printed materials of me (or my son/daughter/ward if participant is under 18 years of age) for promotional and educational activities or other uses for the benefit of H.O.R.S.E. Therapies, Inc.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# H.O.R.S.E. Therapies, Inc

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## VOLUNTEER AGREEMENT

### HOLD HARMLESS/ LIABILITY RELEASE FORM

The undersigned participant, and his/her parent or legal guardian, if the participant is under the age of 18 years, does/do hereby execute this release, waiver and indemnification for himself, herself/themselves and his/her/their heirs, successors, representatives and assigns, acknowledges the inherent risk involved in riding or working around horses, which risks include bodily injury from using, riding or being in close proximity to horses among other risks, and further that both horse and rider can be injured in normal use, competition or schooling.

In consideration for the privilege of riding and working around horses at the Jacksonville Equestrian Center, the undersigned does hereby agree to hold harmless and indemnify, and further release H.O.R.S.E. Therapies, Inc., Jacksonville Equestrian Center, NFES and the City of Jacksonville, from any and all liability, loss, damage, costs, claims and/or causes of action including, but not limited to all bodily injury and property damage arising out of participation in the activity. It being specifically understood that said activity includes the handling of equines by the undersigned participant. This also includes any accident, damage, injury or illness to undersigned or any horse owned by such or to any family member, spectator accompanying the undersigned on the premises of the Jacksonville Equestrian Center.

I fully understand that horseback riding is a dangerous activity. Under Florida Law, an equine activity sponsor or equine professional is not liable for any injury to, or the death of a participant in equine activities resulting from the inherent risk of such activities. I wish to participate in these activities knowing that they are dangerous.

In exchange for being able to participate in these activities, for myself, my heirs, successors, representatives, assigns and legal representative. I release and agree not to make or bring any claim of any kind against H.O.R.S.E. Therapies, Inc., the Jacksonville Equestrian Center, NFES or the City of Jacksonville or its officers, directors, members, employees or guests for any damage to me or my property whether from anyone's negligence or not, or any other cause, arising out of my participation in equine activities. If anyone makes claims because of any injury to me (including death), or for any damage to my property, I will keep all those released by this agreement free of any damages or costs due to those claims. Furthermore, my signature hereby indicates my agreement to obey all rules set forth by the Jacksonville Equestrian Center.

I, \_\_\_\_\_ am voluntarily entering into this Release and Hold Harmless Agreement.

Participant's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

OR

I, \_\_\_\_\_ am the parent/legal guardian of \_\_\_\_\_.

I have read the agreement above, and give permission for him/her to participate in all equine activities.

Guardian's Signature: \_\_\_\_\_ Date: \_\_\_\_\_