



SHADOW HILLS RIDING CLUB

VOLUNTEER REGISTRATION CHECK LIST

All of the forms listed below are required to be completed, checked, signed and dated as indicated prior to the start of volunteer participation.

To be completed by volunteer, parent or caregiver

- 1. Staff/Volunteer Application
2. Photo and Video, Liability and Confidentiality Release
3. Authorization for Emergency Treatment Form
4. General information, Letter of Appreciation, Driver's License/ID Card Copy
5. Training manual provided.
6. Volunteer Handbook Compliance Form

STAFF/VOLUNTEER APPLICATION

Name \_\_\_\_\_ D.O.B. \_\_\_\_\_ Age: \_\_\_\_\_

Height \_\_\_\_\_' \_\_\_\_\_" Please circle: Male Female

Address \_\_\_\_\_ City \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_ Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_ Email \_\_\_\_\_

School or Place of Employment \_\_\_\_\_

First Aid Certified Y N Date \_\_\_\_\_ CPR Certified Y N Date \_\_\_\_\_

Have you ever been convicted of a criminal offense? Y N Date \_\_\_\_\_

Where? \_\_\_\_\_ Please explain \_\_\_\_\_

Do you have any health conditions that may prevent you from working or volunteering? Y N

Please explain \_\_\_\_\_

Do you belong to a group that would like to hear more about Shadow Hills Riding Club? Y N

Does your employer have a donation-matching program? Y N

The above information may be verified, and I give permission for inquiry to be made as to my suitability to act as a client and/or volunteer at Shadow Hills Equestrian Center or Shadow Hills Riding Club.

Printed Name \_\_\_\_\_ Date \_\_\_\_\_

Signature and/or Parent or Guardian \_\_\_\_\_ Date \_\_\_\_\_

Table with 7 columns: For Office Use Only, Orientation, Training, Inst. Training, Emergency, Volunteer Handbook, Compliance Form Provided. Rows include Name and Date Completed.



SHADOW HILLS RIDING CLUB

## STAFF/VOLUNTEER RELEASE

### PHOTO RELEASE

\_\_\_\_\_ I consent to and authorize

\_\_\_\_\_ I do not consent to nor do I authorize

The use and reproduction by Shadow Hills Riding Club and/or Shadow Hills Equestrian Center, of all photographs and any other audiovisual materials taken of me for promotional printed material, educational activities exhibition, or for the benefit of the program.

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

### LIABILITY RELEASE

I acknowledge the risks and potential for risks of horseback riding and activities in and around a facility where horses are kept and farm machinery operated. However, I feel that the possible benefits to myself/my child/my ward are greater than the risk assumed. Intending legally to bind myself, my heirs and assigns, executors or administrators, I hereby waive and release forever all claims for damages against Shadow Hills Equestrian Center and the non-profit program Shadow Hills Riding Club and its Board of Directors, Instructors, Therapists, Aides, Volunteers, Employees for any and all injuries and losses I/my child/my ward may sustain while participating in Shadow Hills Riding Club's therapeutic riding program. This release includes without limitation the risk of negligent instruction and supervision. I engage in activities at Shadow Hills Equestrian Center voluntarily with knowledge of the risks and I assume all risks of injury, death, and property damage that may result. I agree to bear any loss myself. I acknowledge that Shadow Hills Equestrian Center and the property owners are materially relying on this waiver and assumption of risk in allowing me or my child/my ward to participate in activities at Shadow Hills Equestrian Center.

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

Signature of Parent or Guardian \_\_\_\_\_ Date: \_\_\_\_\_

### CONFIDENTIALITY AGREEMENT

I understand that all of the information (written and verbal) about participants at this PATH center is confidential and not to be shared with anyone without expressed written consent of the participant and their parent/legal guardian in the case of a minor.

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



## AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT FORM

Participant/Staff/Volunteer Name \_\_\_\_\_ D.O.B. \_\_\_\_\_

Phone \_\_\_\_\_

Address \_\_\_\_\_

Physician's Name \_\_\_\_\_ Phone \_\_\_\_\_

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 \_\_\_\_\_

### CONSENT FOR EMERGENCY MEDICAL TREATMENT

In the event that Emergency medical aid/treatment is required due to illness or injury during the process of receiving services from, or while being on the property of, Shadow Hills Equestrian Center, I authorize Shadow Hills Equestrian Center 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.

This authorization includes x-rays, 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.

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

### NON-CONSENT FOR EMERGENCY MEDICAL TREATMENT

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 Shadow Hills Equestrian Center. Parent or legal guardian will remain on site at all times during equine assisted activity in the event that emergency treatment/aid is required, I wish that the following procedure take place:

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



SHADOW HILLS RIDING CLUB

GENERAL INFORMATION

Please tell us about your experience with:

Horses: \_\_\_\_\_

People with disabilities: \_\_\_\_\_

How did you learn about SHRC? \_\_\_\_\_

I am interested in being involved in the following areas:

- \_\_\_ Horse Handling/Daily Turnout \_\_\_ Horse Shows \_\_\_ Trail Rides
\_\_\_ Side-Walking \_\_\_ Leading \_\_\_ Fundraising
\_\_\_ Stable Cleaning \_\_\_ Office Work \_\_\_ Special Events
\_\_\_ Ranch Improvements \_\_\_ Monthly Newsletter \_\_\_ Photography/Video

I understand that I must give SHRC a notice of at least 24 hours if I cannot make my scheduled time.

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

LETTER OF APPRECIATION

On behalf of Shadow Hills Equestrian Center and Shadow Hills Riding Club, we would like to thank you for volunteering your valuable time and energy for the ongoing growth of our program. Volunteer work is established as a "no compensation position". Accumulated volunteer hours are not to be exchanged for goods or services.

I have read and understand this agreement.

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

Please attach a copy of your driver's license, First Aid certification or CPR certification (if applicable).



SHADOW HILLS RIDING CLUB

I, \_\_\_\_\_, hereby acknowledge and declare that:  
Print Name

- (i) I am aware that Shadow Hills Riding Club's policies are available in the volunteer handbook. It is my responsibility to familiarize myself with these policies.
- (ii) I have received the volunteer handbook and understand the content included.
- (iii) I agree to conduct my activities in accordance with Shadow Hills Riding Club's policies and understand that breaching these standards may result in disciplinary action up to and including termination .

Signed: \_\_\_\_\_

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