



**Therapeutic Horsemanship**  
**(864)871-1744**

## **Volunteer Information Form**

### **General Information**

Name: \_\_\_\_\_ Home phone: \_\_\_\_\_  
Address: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
\_\_\_\_\_ Cell Phone: \_\_\_\_\_  
E-mail: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Would you prefer to volunteer for horse related activities or non-horse related lessons activities?

Are you willing to commit to a regular schedule of volunteering? \_\_\_\_\_

On which days and times can you volunteer? \_\_\_\_\_

Please briefly list any relevant experience you have working with horses or handicapped individuals.

### **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 hospitalization/surgeries, or lifestyle changes.

### **Allergies:**

### **Medications:**

Please list any current **first aid** or **CPR** certifications: \_\_\_\_\_

*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 program.*

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

### **Background Information**

Have you ever been charged with or convicted of a crime? No Yes, please explain:

I, \_\_\_\_\_ (volunteer/staff), authorize "Lets Saddle Up" 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 conviction 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 "Lets Saddle Up", 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:** \_\_\_\_\_

Current Driver's License Y N License Number \_\_\_\_\_ State \_\_\_\_\_

**Photo Release-** I hereby consent to and authorize the use and reproduction by Let's Saddle Up of any and all photographs and any other audiovisual materials taken of me/my child/my ward for promotional printed material, educational activities or for any other use for the benefit of the program. It is our policy, that names will not be attached to the photographs.

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

**Confidentiality Agreement**

*I understand that all information (written or verbal) about participants at this 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:** \_\_\_\_\_

**Liability Release**

Under South Carolina law, an equine activity sponsor or equine professional is not liable for an injury to or the death of a participant in an equine activity resulting from an inherent risk of equine activity, pursuant to Article 7, Chapter 9 of Title 47, Code of Laws of South Carolina, 1976.

*I understand that acting as a volunteer for "Lets Saddle Up", may be a high-risk activity and I am participating at my own risk. I do further release and hold harmless "Lets Saddle Up" and all members of their organizing committee, agents and employees, from all liability for accidents, damage, injury or illness suffered while acting as a volunteer for, or while being on the property of "Lets Saddle Up".*

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

Parent or guardian must sign if volunteer is under 18 years of age:

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

***Emergency Medical Authorization***

Name (please print): \_\_\_\_\_  
Physician's Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
Preferred Medical Facility: \_\_\_\_\_  
Health Insurance Co.: \_\_\_\_\_ Policy#: \_\_\_\_\_  
Emergency Contacts:  
Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Phone: \_\_\_\_\_  
Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Phone: \_\_\_\_\_

*In the event emergency medical aid/treatment is required due to illness or injury while acting as a volunteer for, or whole being on the property of the agency, I authorize an adult associated with "Lets Saddle Up",*

- 1. to secure and retain medical treatment and transportation on my behalf if needed*
- 2. to release my records upon the request to the authorized individual or agency involved in the medical emergency treatment.*

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

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

Parent or guardian must sign if volunteer is under 18 year of age:

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