

Dreams Come True Therapeutic Riding
Therapeutic Riding Program
639 County Road 513
Pittstown NJ 08867-5162
office phone: 908-735-5912

Volunteer/Staff Information Form and Health History

Name: _____ Date _____

Address: _____ City _____ State _____ ZIP _____

Employer/School: _____

Work Address: _____

Date of Birth: _____ Phone: (H) _____ (W) _____

Email Address: _____

Parent/Legal Guardian Name and Address: _____

How did you learn about the program? _____

Check the areas in which you are interested:

Program Volunteer

- Leading a Horse
- Sidewalking with a student
- Stable management
- Facility Repairs
- Instructor

Competition

- Horse Show
- Away Horse Shows
- Special Olympics
-
-

Friends of Therapeutic Riding

- Fundraising
- Photography/Video
- Volunteering at Fundraisers
-
-

Releases

- I DO
 DO NOT

Consent to an authorize the use and reproduction by Dreams Come True Therapeutic Riding Program of any and all photographs and any other audio/visual materials taken of me/my child for promotional material, educational activities, exhibitions or for any other use for the benefit of the program.

In addition:

I/my child would like to participate in the Hunterdon County Education Foundation Therapeutic Riding Program as a volunteer. I acknowledge the risks and potential for risks of horseback riding and working around horses. However, I feel that the possible benefits to me/my child are greater than the risk assumed. I hereby, intending to be legally bound, for myself, my heirs and assigns, executors or administrators, waive and release forever all claims for damages against Dreams Come True Therapeutic Riding, its Board of Directors, Instructors, Therapists, Aides, Volunteers and/or Employees and the Hunterdon County Education Foundation for any and all injuries and/or losses I/my child may sustain while participating in DCTTR activities.

Signature: _____ Date: _____
(Volunteer, parent or legal guardian)

Witness: _____ Date: _____

Authorization for Emergency Medical Treatment

Name: _____

Physician's Name: _____ Medical Facility: _____

Health Insurance Company: _____ Policy Number: _____

Allergies: (medications and other) _____

Medical Conditions: _____

Current Medications: _____

In the event of an emergency contact:

Name: _____ Relation: _____ Phone: _____

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 Dreams Come True Therapeutic Riding Program, I authorize the Dreams Come True Therapeutic Riding Program to:

1. Secure and retain medical treatment and transportation if needed.
2. Release pertinent 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 emergency contact(s) above is(are) unable to be reached.

Consent Signature: _____ Date: _____
(Volunteer, parent or legal guardian)

Witness: _____ Date: _____