

DATE: _____

Volunteer Information Sheet

Cedar Creek Therapeutic Riding Center – 4895 East Highway 163, Columbia, MO 65201

(Please print all information)

First and last Name: _____ Social Security # _____

Birthdate ____/____/____ Are you currently a student? _____ Where? _____
(mm/dd/yyyy)

Local address _____

Permanent address: _____

Phone number (*home*) _____ (*cell/work*) _____

E-mail address: _____

Can you provide a copy of current certification in CPR/First Aid training? _____

Can you provide a copy of a recent criminal background check? _____

Authorization for Emergency Medical Treatment

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 Cedar Creek Therapeutic Riding 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 emergency Medical treatment.

In the event I cannot be reached: Contact: _____ Phone _____

Contact _____ Phone _____

Physician's name: _____ Phone _____

Preferred Medical Facility: _____ Phone _____

Health Insurance Company: _____ Policy# _____

Allergies: _____

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 above cannot be reached

Date: _____ Consent Signature _____

Volunteer (*Parent or Guardian if under 18*)

OR

Non-Consent Plan

I ***DO NOT*** give my consent for emergency medical treatment in the case of illness or injury during the process of providing volunteer services while being on the property of the agency. ***PLEASE ATTACH A WRITTEN DESCRIPTION OF THE EMERGENCY PROCEDURE THAT YOU WISH US TO FOLLOW, SIGNED BY THE VOLUNTEER, PARENT OR GUARDIAN.***

Date: _____ Non-Consent Signature _____

Volunteer (*Parent or Guardian if under 18*)

Please list any medical conditions that could affect you while you are at CCTRC. This information will be kept confidential and will only be used for medical emergencies.

*****IF YOU HAVE A MEDICAL CONDITION, A COMPLETE MEDICAL HISTORY SHOULD BE ATTACHED*****

I would like to volunteer as a (check one or more) _____ Leader (some horse experience),
_____ Sidewalker (no horse experience required); _____ Groom (brush horses, muck stalls, clean tack)

My experience with horses: _____

I would be interested in helping with one or more of the following projects:

_____ Folding/labeling newsletters _____ Fundraising projects _____ Building projects/work days
_____ Cleaning tack, bathing, grooming and braiding horses for horse shows, parades and Boone County Fair

★ ★

- I hereby acknowledge that I have been trained to volunteer as a leader/sidewalker for therapeutic horseback riding. I understand my responsibilities and that I am expected to show up on the day and time to which I have agreed.
- I have read and understand the volunteer training manual.
- If I cannot come at my appointed day and time, I will try to call ahead of time [(573) 875-8556].
- I acknowledge the risks and potential risks associated with the work involved with therapeutic horseback riding. I hereby, intending to be legally bound, waive and release forever all claims for damages against Cedar Creek Therapeutic Riding Center, its Board of Directors, Instructors, Therapists and/or Employees for any and all injuries and/or losses I may sustain while participating in events and activities at Cedar Creek Therapeutic Riding Center.
- I will adhere to the confidentiality policy of CCTRC, which states, in part, that all client information will remain confidential. This also restricts the use of photographs of clients (and volunteers) without express permission.

Signature (*Parent/Guardian signature if under 18*): _____
Date: _____

To help in its fundraising efforts, CCTRC would like to contact your employer. Please complete the following:
Employer Name and Phone: _____ OK to Contact _____

Photo Release

I hereby consent to and authorize the use of reproduction by CCTRC of any and all photographs and any other audio/visual materials taken of me for promotional printed material, educational activities, exhibitions or for any other use for the benefit of the program.

I do not consent to the use of photographs or audio/visual materials taken of me for any use by CCTRC.

Date: _____ Signature: _____