REINS Equine-Assisted Activities and Therapies Volunteer Application

Please Print Clearly

Name: _____Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____E–Mail: _____

(For volunteers under 18 years of age)

Parent/Guardian Name: _____ Phone: _____

Address: _____

Most Recent Employment/School: _____ Occupation: _____

My employer gives me time off for volunteering: _____ My employer matches cash donations: _____

How did you hear of REINS? _____

Are there others from your household involved in REINS? _____ If so, please list their names below:

_____

_____

Do you have experience with people who have special needs? ___ Yes ____ No

Do you have experience with horses? ___Yes ___No

T-shirt Size (circle one): S M L XL XXL XXXL

Please place a check by the roles you are interested in hearing more about:

Sidewalker (must be 14 or older) _____

Horse Leader (must be 14 or older) ____

Groom (must be 12 or older) _____

Equipment Assistant (must be 12 or older) _____

Workdays: _____

Board of Directors: _____

Serving on a committee: _____

Other _____

PLEASE READ EACH OF THE FOLLOWING ITEMS BEFORE SIGNING

Photo & Publicity: I hereby consent to & authorize the following; _____ I do not consent, nor authorize the following_____:

1) REINS, Inc. Equine Assisted Activities and Therapies may use my (my child's) photograph or image in its print, online and video publications; 2) release REINS, Inc. Equine Assisted Activities and Therapies, its employees and any outside third parties from all liabilities or claims that I might assert in connection with the above-described activities and 3) I waive any right to inspect, approve or receive compensation for any materials or communications, including photographs, videotapes, DVDs, website images or written materials, incorporating photos/images of me (my child).

Liability Release: I acknowledge the risks and potential for risks of horseback riding and related equine activities including grievous bodily harm. However, I feel that the possible benefits to myself are greater than the risks 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 REINS, Inc. Equine Assisted Activities and Therapies and Majestic Crossing Dairy, LLC, its Board of Directors, instructors, therapists, aides, volunteers, and/or staff members for any and all injuries and/or losses I may sustain while participating as a REINS volunteer/staff member from whatever cause including, but not limited to, the negligence of these related parties.

The undersigned acknowledges that he/she has read this Volunteer Application Form in its entirety, that he/she understands the terms of this release and has signed this release voluntarily and with full knowledge of the effects thereof. (If volunteer/staff is under 18 years of age, both parent and volunteer/staff signatures are required.)

Date: _____ Signature: _____

Date: _____ Signature: _____

Confidentiality Policy: At REINS we place great importance on protecting the confidential information of our participants, our staff and our volunteers. "Confidential Information" includes, but is not limited to, personally identifiable information such as surnames, telephone numbers, addresses, e-mails, etc., as well as the non-public business records of REINS. In particular, medical information about participants and their disabilities or special needs must be protected as Confidential Information. Volunteers/staff shall never disclose Confidential Information to anyone other than REINS personnel. Volunteers/staff must seek permission before taking any pictures or videos. I have read and understand the REINS Confidentiality Policy and agree to abide by same. (If volunteer/staff is under 18 years of age, both parent and volunteer/staff signatures are required.)

Date: _____ Signature: _____

Date: _____ Signature: _____

Authorization for Emergency Medical Treatment for Volunteers

In the event emergency medical aid/treatment is required due to illness or injury while on the property during the process of volunteering or working with the program, I authorize REINS, Inc. to:

1) Secure and retain medical treatment and transportation, if needed. 2) Release volunteer/staff records upon request to the authorized individual or agency involved in the medical emergency treatment.

Name of Volunteer: _____ DOB: _____ Phone(s): _____

Address: _____

Email Address: _____

In the case of Emergency contact one of the following:

Name: _____ Relation: _____ Phone(s): _____

Name: _____ Relation: _____ Phone(s): _____

Physician's Name: _____Town: _____ Phone: _____

Preferred Medical Facility: _____ Health Insurance Co: _____ Policy #: _____

Please indicate any allergies: _____

Current Medications: _____

Recent medical tests: Last Tetanus Shot: _____Tuberculosis Test + Date: _____

(Consult your physician or local health department if you are not up to date with these shots/tests)

Please indicate any disability, limitations, medications or medical conditions that may affect your volunteer/staff role. Describe your current health status, particularly regarding physical/emotional demands of working in an equine assisted program. Address fitness, cardiac, respiratory, bone/joint function or recent hospitalizations or surgeries.

_____

_____

Medical Treatment **Consent** Plan: This authorization includes x-rays, surgery, hospitalization, medication and any treatment procedure deemed "lifesaving" by the physician in the event of illness or injury while working with the program. This provision will only be invoked if the person(s) above is unable to be reached. (For volunteer under 18 years of age, both parent & volunteer signatures are required):

Date: _____ Consent Signature: _____

Date: _____ Consent Signature: _____

Medical Treatment **Non-Consent** Plan: I do not give my consent for emergency medical treatment/aid in the case of illness or injury while working with the program. (For volunteer under 18 years of age, both parent & volunteer signatures are required):

In the event emergency treatment/aid is required, I wish the following procedure to take place:

_____

_____

Date: _____ Non-Consent Signature: _____

Date: _____ Non-Consent Signature: _____