Special Equestrians, Inc.

PO Box 61528
Fort Myers, FL 33906-1528
telephone: 239.226.1221
fax: 239.226.1279
email: spequestrians@gmail.com
website: www.specialequestrians.net

Volunteer/Staff Information Form and Health History

General Information

Name: ____________________________Date of Birth: __________ Date: ________________

Local Address: __________________________ Summer Address: __________________________

Street: __________________________ Street: __________________________

City: __________________________ City: __________________________

State: __________ Zip: __________ State: ______ Zip: ________ Phone: ________

Local Phone: (H) ________ (W) ________ (C) ________ Email:________________

Employer/School: ____

Parent/Legal Guardian/Caregiver - Name, Address and Phone Number________________________

____

How did you learn about the program? ____

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 hospitalizations/surgeries or lifestyle changes.

____

____

____

____

Place a **CHECK MARK** next to any **DAY/TIME** you are available to volunteer. Program class times are highlighted in yellow.
NOTE: We need volunteers on all days and times, to fill our many different types of volunteer needs.

Monday	AM	PM	**Tuesday**	AM	PM	**Wednesday**	AM	PM
Thursday	AM	PM	**Friday**	AM	PM	**Saturday**	AM	PM

Place a CHECK MARK next to the AREAS where you would like to volunteer:

Program Services
_______Horse Leading
_______Sidewalking for a rider
_______Horse Care
_______Equipment Cleaning
_______Horse Transport
_______Facility Repair
_______Grounds Care, General Cleanup
_______Building Projects
_______Hay Delivery Day at SE facility
_______Office Cleaning

Administrative Support
________ Computer skills
________Thank you letters
________General Office Duties
________Telephone Calling

Public Relations
________Program Presentations
________Civic Events
________Newsletter (online)
________Advertising

Fund-Raising
________Special Events
________Grant-Writing
________Taste of Love
________Rideathon

Other **skills or training that would be helpful to our program**:

____

____

I understand that the information provided is accurate to the best of my knowledge. I know of no reason why I should not participate in this center's program.

► **Signature**________________________________◄ **Date** ______________

Volunteer/Staff Information Form and Health History –

Name: ____

Address: ____

Phone: ____ Date of Birth: __________________

Photo Release
I DO
DO NOT
consent to and authorize the use and reproduction by Special Equestrians, Inc. of any and all photographs and any other audio/visual materials taken of me for promotional material, educational activities, exhibitions
or for any other use for the benefit of the center.

► Signature____◄ Date ________________
(Volunteer/Staff)

Background Information

Have you ever been charged with or convicted of a crime? Y N; please explain ___________________

____

____

I, _________________________________ (volunteer/staff), authorize Special Equestrians to receive information from any law enforcement agency, including police departments 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 convictions 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 the PATH Intl. center, 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 ________________
(Volunteer/Staff)

CURRENT DRIVER'S LICENSE (check one): Y N

DRIVER'S LICENSE NUMBER ________________________________ STATE______________

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Emergency Medical Treatment Form

____ Participant ____ Volunteer ____ Staff

Name: ______________________________________ DOB: ________________ Phone: ______________

Address: __________________________________ City: _________________ State: _____ Zip: _______

Physician's Name: _________________________ Preferred Medical Facility: ______________________

Health Insurance Company: _________________________ Policy #: ______________________________

Recent medical tests: Last Tetanus Shot: ___________ Tuberculosis Test + - Date: ____________

Allergies: ____

Current medications: ____

In the event of an emergency, contact:____

Name: __________________________________ Relation: _________________ Phone: _______________

Name: __________________________________ Relation: _________________ Phone: _______________

Name: __________________________________ Relation: _________________ Phone: _______________

In the event that 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, Special Equestrians, Inc. will determine if emergency services should be contacted. The injured adult or legal guardian/parent has the right to refuse treatment from the emergency responders; however Special Equestrians will call for emergency medical treatment services, when it is deemed necessary by our staff.

In the event of needed emergency medical treatment, Special Equestrians will:

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

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

Date: _____________ Consent Signature: ____

Participant, Volunteer, Staff, Parent or Legal Guardian

Signed in presence of center staff

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Side Walking and Horse Leading Questionnaire

Our Special Equestrians volunteers are a vital part of the program. Up to three volunteers may be needed for each rider, to either lead the horses and ponies or act as side walkers. For that reason, the program needs to rely upon many volunteers for each riding session. Without the volunteers, the program could not exist or expand to include a greater number of participants/riders. **Currently classes are held on Wednesday and Saturday mornings from 9 AM to 12 Noon, on Tuesday afternoon from 4 PM to 6 PM, and on Thursday afternoon from 3 PM to 6 PM.** Volunteers are asked to come one hour before classes begin, to help prepare the horses and set up the arena for classes.

Side walkers walk next to the horse during the class session and provide various degrees of support to the rider. No previous experience is needed but this is a physical job that entails strength in the arms and ability to walk for at least 45 minutes. Some short distance jogging may be involved if you are able, but this is not mandatory to be a side walker.

Horse leaders must be familiar with horses and be able to lead the horse, keeping it calm and under control during the class session. Horse leaders for the program must use the leading techniques which are taught and used by Special Equestrians. Our leading techniques are based on Natural Horsemanship methods.

The following questions will help to determine whether you will be able to meet the criteria needed for these jobs. We will have volunteer training to familiarize volunteers with our techniques and requirements.

Do you have physical limitations? Please be specific ____

Can you walk for 45 minutes? _______________ Can you jog for short distances? _________________

Given a chance to change sides frequently, can you hold your arms above shoulder height and support modest weight? ____

Are you comfortable working around horses/ponies? ____

Do you have experience with horses or ponies? _______Specify_________________________________

Have you had riding experience? Describe____

____

Volunteer Attire Policy

Volunteers may not wear open-toed shoes or sandals when working near the horses. Volunteers must wear sturdy closed-toed shoes or boots that offer foot protection. Dangling jewelry is unsafe to wear with some participants. Refrain from wearing dangling jewelry during the program. Please do not wear perfume or cologne, as it can attract bees and other biting insects. In addition, some of our participants are allergic to perfume and cologne.

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VOLUNTEER RELEASE AGREEMENT

I, ________________________________, VOLUNTEER FOR, AND IN CONSIDERATION OF THE AGREEMENT OF THE SPECIAL EQUESTRIANS, INC., DOES/DO HEREBY FOREVER RELEASE, ACQUIT, DISCHARGE AND HOLD HARMLESS THE SPECIAL EQUESTRIANS, INC., ITS OFFICERS, TRUSTEES, AGENTS, EMPLOYEES, REPRESENTATIVES, SUCCESSORS, AND ASSIGNS, FOR ALL MANNER OF CLAIMS, DEMANDS AND DAMAGES OF EVERY KIND AND NATURE WHATSOEVER, WHICH THE UNDERSIGNED OR VOLUNTEER MAY NOW, OR IN THE FUTURE, HAVE AGAINST THE SPECIAL EQUESTRIANS, INC. ITS OFFICERS, TRUSTEES, AGENTS, EMPLOYEES, REPRESENTATIVES, SUCCESSORS OR ASSIGNS ON ACCOUNT OF ANY PERSONAL INJURIES, PHYSICAL OR MENTAL CONDITION, KNOWN OR UNKNOWN, TO THE PERSON AND THE TREATMENT THEREFORE AS A RESULT OF, OR IN ANY WAY GROWING OUT OF THE ACTS OF THE SPECIAL EQUESTRIANS, INC., ITS OFFICERS, TRUSTEES, AGENTS, EMPLOYEES, REPRESENTATIVES, SUCCESSORS OR ASSIGNS, INCLUDING, BUT NOT LIMITED TO, THEIR NEGLIGENCE OR GROSS NEGLIGENCE, IN PARTICIPATION IN THE PROGRAM OR IN ANY WAY INCIDENTAL THERETO.

WARNING: UNDER FLORIDA LAW, AN EQUINE ACTIVITY SPONSOR OR EQUINE PROFESSIONAL IS NOT LIABLE FOR ANY INJURY TO, OR THE DEATH OF, A PARTICIPANT IN EQUINE ACTIVITIES RESULTING FROM THE INHERENT RISK OF EQUINE ACTIVITIES.

DATE: ____

SIGNED: ____

VOLUNTEER SIGNATURE (PARENT OR GUARDIAN, IF UNDER 18)

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Confidentiality Policy for Special Equestrians, Inc.

1. Riders and their families, staff members, and volunteers have a right to privacy that gives them control over the dissemination of their medical or other sensitive information. The therapeutic riding center shall preserve the right of confidentiality for all individuals in its program.

2. The staff shall keep confidential all medical, social, referral, personal and financial information regarding a person and his/her family. Any person who accidentally obtains such information must not disclose it to anyone without proper authorization.

3. Anyone who works or volunteers for, or provides services to, the therapeutic riding center is bound by the confidentiality policy, including but not limited to: full- and part-time staff, independent contractors, temporary employees, volunteers, and board members.

4. A person must be over the age of 18 to give consent for disclosure of medical or sensitive information. For anyone under the age of 18, only parent(s), legal guardian or other legal representatives may give consent for disclosure. Adults with developmental disabilities are presumed legally competent to give or deny disclosure unless they have been adjudicated incompetent to make this type of health care decision. If a substitute decision maker has been appointed, written consent must be obtained from that individual.

5. Disclosure of private or sensitive information will not be given out without a person's consent based on a *perceived* need to protect staff or anyone else from possible exposure through casual contact. EVERYONE should commonly practice infection control procedures with all riders and volunteers under the assumption that anyone could have HIV, hepatitis, or other blood-borne diseases. Casual contact poses NO RISK of transmission of diseases such as HIV.

6. Information will be disclosed to outside agencies or individuals only with the specific written consent of the rider or client (or volunteers due to a medical emergency).

7. Breach of this confidentiality policy may result in reprimand, loss of certain job/volunteer responsibilities, or termination of services/employment, to be determined by the Program Director and/or Board of Directors based on the severity of the breach.

I understand and will observe the confidentiality policy of Special Equestrians, Inc.

Signature: ____ Date: _________________________

(Signature required of all staff, volunteers, independent contractors, board members, and temporary employees)