



Special Equestrians, Inc.

PO Box 61528 • Fort Myers, FL 33906-1528
239-226-1221 (O) • 239-226-1279 (F)

www.specialequestrians.net • se@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? _____

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

Health History

Describe your current health status, particularly regarding the physical/emotional demands of working in a therapeutic riding program. Please list any physical challenges that might make sidewalking or leading a challenge for you. Sidewalkers & horse leaders may walk for 45 minutes at a time. If this would be difficult for you, we have many other areas we need help in.

Allergies: _____

Medications: _____

Place a "Y" next to the times you are available to volunteer:

Mon. ____AM ____PM Wed. ____AM ____PM Fri. ____AM ____PM Sun. ____AM ____PM

Tues. ____AM ____PM Thurs. ____AM ____PM Sat. ____AM ____PM

Please put an "X" in the box next to the areas where you would like to volunteer:

Program Services

Administrative Support

Public Relations

Fund-Raising

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> Horse Leading | <input type="checkbox"/> Typing | <input type="checkbox"/> Program Presentations | <input type="checkbox"/> Special Events |
| <input type="checkbox"/> Sidewalking a rider | <input type="checkbox"/> Correspondence | <input type="checkbox"/> Participating in Civic Events | <input type="checkbox"/> Rideathon |
| <input type="checkbox"/> Horse Care | <input type="checkbox"/> General Office Duties | <input type="checkbox"/> Newsletter & Brochure | <input type="checkbox"/> Grant-Writing |
| <input type="checkbox"/> Equipment care & cleaning | <input type="checkbox"/> Telephone Calling | <input type="checkbox"/> Advertising | <input type="checkbox"/> Fund-Raising |

Horse Transport (must own a trailer) **Other skills or training that would be helpful to our program:** _____

Facility Repair _____

Grounds Care, General Cleanup _____

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: _____

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 NARHA 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 Y N LICENSE NUMBER _____ STATE _____



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Authorization for Emergency Medical Treatment Form

___ Participant ___ Staff ___ Volunteer

Name: _____ DOB: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Physician's Name: _____ Preferred Medical Facility: _____

Health Insurance Company: _____ Policy #: _____

Allergies to medications: _____

Current medications: _____

In the event of an emergency, contact:

Consent Plan

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 Special Equestrians, Inc. 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 medical emergency treatment.

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(s) above is unable to be reached.

Date: _____ Consent Signature: _____

Participant, Parent or Legal Guardian
Signed in presence of center staff

Non-Consent Plan

I do not give my consent for emergency medical treatment/aid in the case of illness or injury during the process of receiving services or while being on the property of the agency.

- Parent or Legal Guardian will remain on-site at all times, during equine assisted activities.
- In the event emergency treatment/aid is required; I wish the following procedures to take place:

Date: _____ Non-Consent Signature: _____

Participant, 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 are 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 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 taught and used by Special Equestrians which are based in Natural Horsemanship methods, particularly Parelli.

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** 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

Phone Number: _____

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 ANYWAY 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 ANYWAY INCIDENTAL THERTO.

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)

WITNESSED: _____



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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)



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Partner Agency

RELEASE OF LIABILITY

PLEASE READ BEFORE SIGNING:

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THE UNDERSIGNED RIDER AND ANY SIGNING PARENT OR GUARDIAN HEREBY AGREES TO RELEASE SPECIAL EQUESTRIANS, INC., THEIR OFFICERS, DIRECTORS, EMPLOYEES, MEMBER OR AGENTS, AND THE OWNERS OR MANAGERS OF THE GROUNDS WHERE THE RIDING TAKES PLACE FROM ANY LOSS, DAMAGE, LIABILITY OR INJURY ARISING OUT OF OR RESULTING FROM THIS RIDING OR RIDER'S PARTICIPATION THEREIN, INCLUDING THE NEGLIGENT ACTS OR OMISSIONS OF THE MANAGEMENT OF SPECIAL EQUESTRIANS, INC., THEIR OFFICERS, DIRECTORS, EMPLOYEES, MEMBERS OR AGENTS, AND THE OWNERS OR MANAGERS OF THE GROUNDS WHERE THE RIDING IS TAKING PLACE.

RIDER'S PRINTED NAME

RIDER'S SIGNATURE (PARENT OR GUARDIAN, IF UNDER 18)

DATE _____