1006 130th Street
Aberdeen, SD 57401
605-226-1099
spurs@nrctv.com
www.SPURSAberdeen.org

SPURS
Therapeutic Riding Center

Special People Using Riding Skills

Volunteers

General Information

Name:_____ Phone (H):_____ Phone (W):_____

Address:_____

Employer / School:_____ DOB:_____

Employer / School Address:_____

Parent / Legal Guardian / Caregiver Name:_____ Phone:_____

Address:_____

How did you learn about the SPURS program?_____

Experience

What type of experience have you had with horses (if any)?_____

_____

Have you volunteered / worked with any other therapeutic riding programs? ❑ Yes ❑ No If yes, explain responsibilities:

_____

References

Please provide two employment / volunteer or personal (non-family member) references.

Name:_____ Type: ❑ Work ❑ Volunteer Personal Phone:_____

Name:_____ Type: ❑ Work ❑ Volunteer Personal Phone:_____

Interest / Availability

What days / times are you available to volunteer / work?_____

Please check what areas you are interested in helping with:

Program: ❑ Horse Handling ❑ Side-walking with a student ❑ Stable Management ❑ Facility Repairs

Special Events: ❑ Fundraising ❑ Special Olympics

Administration: ❑ Public Relations ❑ Grant Writing ❑ Newsletters ❑ Volunteer Recruiting ❑ Audio / Visual

Acknowledgements

I understand that the information provided above 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 / caregiver. Signed in presence of center staff.)

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Photo Release

I (check one) ❑ DO ❑ DO NOT consent to and authorize the use and reproduction by SPURS Therapeutic Riding Center of any and all photographs and other audio / visual materials taken of me for promotional material, educational activities, exhibitions or for any other use for the benefit of the program.

Signature:_____ Date:_____

Background Information

Have you ever been charged with or convicted of a crime? ❑ Yes ❑ No If yes, please explain:_____

_____

_____

I, _____ (volunteer name), authorize SPURS Therapeutic Riding Center to receive information from any law enforcement agency, including the police departments and sheriff 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 committeed upon children or animals.

I understand that such access is for the purpose of considering my application as a volunteer, and I expressly DO NOT authorize SPURS Therapeutic Riding 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:_____

Other Information

Do you have a current driver's license? ❑ Yes ❑ No License Number:_____

Confidentiality Agreement

I understand that all information (written and verbal) about participants at this NARHA center is confidential and will not be shared with anyone without the expressed written consent of the participant and their parent/guardian in the case of a minor.

Signature:_____ Date:_____

Volunteer Liability Release

As a volunteer at SPURS Therapeutic Riding Center. I acknowledge the risks and potential for risks of a horseback riding program. However, I feel that the possible benefits to myself and the clients I work with 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 SPURS Therapeutic Riding Center, its board of directors, instructors, therapists, volunteers and /or employees for any and all injuries and/or losses I may sustain while participating in SPURS Therapeutic Riding Center.

Signature:_____ Date:_____

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Authorization for Emergency Medical Treatment Form

❑ Participant ❑ Staff ❑ Volunteer

Name:_____ DOB:_____ Phone:_____

Address:_____

Physician's Name:_____ Preferred Medical Facility:_____

Health Insurance Company:_____ Policy Number:_____

Known Allergies to Medications:_____

Current Medications:_____

Are there any special health problems that we should be aware of? ❑ Yes ❑ No

Comments:_____

_____

Emergency Contacts

Name:_____ Relation:_____ Phone:_____

Name:_____ Relation:_____ Phone:_____

Name:_____ Relation:_____ Phone:_____

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 SPURS Therapeutic Riding Center to:

1. Secure and retain medical treatment and transportation, if needed.
2. Release client records upon request to 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) listed above is unable to be reached.

Consent Signature:_____ Date:_____

(Client, 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 aid/treatment is reuired, I wish the following procedures to take place:

_____

_____

Consent Signature:_____ Date:_____

(Client, parent or legal guardian. Signed in presence of center staff.)