



Equine Dreams

Volunteer/Staff Information Form and Health History

General Information

Name: _____ Date: _____

Address: _____

DOB: _____ Email address: _____

Phone (H): _____ (W): _____ (C): _____

Employer/School: _____

Address: _____

Parent/Legal Guardian Name and Address: _____

How did you learn about Equine Dreams? _____

Recent medical tests: Last Tetanus Shot: _____ Tuberculosis Test + -- Date: _____
(Consult your physician or local health dept. if you are not up to date on these shots)

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.

Allergies: _____

Medications: _____

Check which areas you are interested in:

Program

- Horse handling
- Side walking
- Stable Mgmt.
- Facility repairs

Special Events

- Horse shows
- Fundraising
- Special Olympics
- Trail rides

Administration

- Public relations
- Grant writing
- Newsletter
- Volunteer Recruitment
- Photography
- Budget/Finance
- Future planning

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 Equine Dreams program.

Signature: _____ Date: _____

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Name: _____

Address: _____

Phone: _____ Date of Birth: _____

PHOTO RELEASE

I DO

DO NOT

consent to and authorize the use and reproduction by Equine Dreams of any and all still and/or video photography 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 program.

Signature: _____ Date: _____
Client, Parent or Legal Guardian

Background Information

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

I, _____, authorize Equine Dreams 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 Equine Dreams, 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: _____

Current Driver's license Y N License number _____ STATE _____

Confidentiality Agreement

I understand that all information (written and verbal) about participants at Equine Dreams 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: _____

EQUINE DREAMS CONFIDENTIALITY STATEMENT

Please check the appropriate box.

New Help Introduction
 Physician / PA / Intern / Resident
 Employee / Student / Agency

Volunteer
 Physician Practice Personnel
 Other: _____

I _____, as an employee, physician, resident, student, physician practice, or volunteer at Equine Dreams:

- Understand that it is my legal and ethical responsibility to maintain the confidentiality of all Patient Medical Records, Employee Information, Financial Information, Proprietary Information, Confidential Information, used in research, and other confidential information relating to Equine Dreams.
- Agree not to disclose any such information or records to any person within or outside Equine Dreams without proper authorization.
- Agree to discuss confidential information only in the work place and only for job related purposes, and to refrain from discussing this information outside of the work place. I agree to discuss confidential information only with other workforce members on a need to know basis. I will refrain from discussing any confidential information within the hearing of other people who do not have a need to know about the information.
- Understand that any and all references to HIV testing, such as any clinical test, laboratory or otherwise used to identify HIV, a component of HIV or antibodies or antigens to HIV, are specially protected by the law.
- Understand that the law specially protects psychiatric and drug abuse records.
- Understand that my access to all electronic systems is audited regularly, and that any inappropriate access to information is prohibited.
- Understand that I am not to share my log-on, user ID, password, or PIN (when applicable) with anyone. Any access to Equine Dreams Information under my log-on is my responsibility.
- Understand that I am responsible to return all keys, pager, ID badges and any other property of Equine Dreams in my possession upon termination.
- Understand that I will report activity that is contrary to the provisions of this Confidentiality Statement to the Privacy Officer.
- Understand that I will annually be asked to review this confidentiality statement and acknowledge understanding upon the evaluation form.
- Understand that violation of any portion of the policies and procedures related to confidentiality of patient records, including the items specified in this statement, or any violation of federal regulations governing the patient's right to privacy will result in disciplinary action up to and including immediate termination of my employment/professional relationship with Equine Dreams and/or possibly lead to legal actions.

I acknowledge that I have read and understand the above statements, Have discussed them with my supervisor, and have had all my questions answered.

Signature

Date

Equine Dreams Authorization for Emergency Medical Treatment Form/ Liability Release

Participant Staff Volunteer

Name: _____ DOB: _____ Phone: _____

Address: _____

Physician's Name: _____ Preferred Medical Facility: _____

Health Insurance Company: _____ Policy#: _____

Allergies to medications: _____ Current medications: _____

In the event of an emergency, contact:

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 **Equine Dreams** 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.
- 3.

This authorization includes x-rays, 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: _____
Client, Parent or Legal Guardian

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 Equine Dreams.

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

Date: _____ Non-Consent Signature: _____
Client, Parent or Legal Guardian

Liability Release

_____ would like to participate in the Equine Dreams activities program. I acknowledge the risks and potential risks of horseback riding. Under the Equine Activity Liability Act, each participant who engages in an equine activity expressly assumes the risks of engaging in and legal responsibility for injury, loss, or damage to person or property resulting from the risks of equine activities. However, I feel that the possible benefits to myself/my son/my daughter/my ward are greater than the risk assumed. I hereby, intending to be legally bound, for myself, my heirs, and assigned executors or administrators, waive and release forever all claims and damages against Equine Dreams, equine activities, it's board of directors, instructors, therapists, aides, volunteers, boarding facilities, boarders, and/or property owners, and/or employees for any and all injuries which I/my son/my daughter/my ward may sustain while participating in the Equine Dreams activities program.

Date: _____ Consent Signature: _____
Client, Parent or Legal Guardian

