PO Box 395
Shrewsbury, VT 05738
(802) 236-2483

Volunteer/staff: General Information

Volunteers must be 14 years or older/ Parent or Guardian signature required for anyone under 18

NAME _____
ADDRESS _____
CITY/STATE/ZIP _____
PHONE (H)_____(W) _____ (C) _____
E-MAIL _____

HOW LONG HAVE YOU LIVED IN VERMONT? _____
EMPLOYER/SCHOOL _____
WORK/SCHOOL ADDRESS _____

PARENT/LEGAL GUARDIAN (IF UNDER 18)_____
ADDRESS _____
CITY/STATE/ZIP PHONE (H) _____ (W) _____ (C)_____
E-MAIL _____

ARE YOU FULFILLING A COMMUNITY SERVICE REQUIREMENT? _____
IF YES, FOR WHICH SCHOOL OR AGENCY? _____
HOW DID YOU HEAR ABOUT REINBOW RIDING CENTER? _____
CURRENT DRIVER'S LICENSE? NO ____ YES-LICENSE # _____State ___

Volunteer Opportunities: _____ Horse Leader ____ Sidewalker ____ Hosting ___ Lesson Prep

These are suggested hours, we are flexible and will adjust to fit your availability

AVAILABLE TIMES	**Mon.**	**Tues.**	**Wed.**	**Thurs.**	**Fri.**	**Sat.**
9:00-11:00						
11:00-1:00						
1:00-3:00						
3:00-5:00						

Able to jog next to the horse? ____ Yes ____ No
Previous horse training/experience? ____ Yes ____ No

Other Opportunities (check all that apply)
__ Dust Busters __ Yard Hand/Posey Possee
Event Extras: ___ Horse Shows ___ Special Olympics ___ Trail Rides
Paper Jockeys: ___ Fundraising ___ Grant Writing ___ Budget/Finance ___ Future Planning ___ Writing/Editing ___ Video/Photography ___ Public Relations ___ Volunteer Recruitment ___ General Office Help
Other _____

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VOLUNTEER/ STAFF: HEALTH INFORMATION

HISTORY: To assist with your safety and the safety of our riders, please describe your current health status, particularly regarding the physical/emotional demands of working in an equine assisted program. Please address fitness, cardiac, bone, or joint function, recent hospitalization/surgeries, or lifestyle changes that might affect your endurance, and/or mobility, or would be important to know about in case of an emergency:

Please list any **medications** that you take that might be important for care providers to be alerted to in case of an accident or need for emergency care:

Please list any **allergies and allergies to medications** that you take that may be important for care providers to know about in case of an accident or need for emergency care:

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VOLUNTEER/STAFF: AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

NAME_____ **DOB**_____
ADDRESS_____
CITY/STATE/ZIP_____
PHONE (H)_____(W)_____(C)_____EMAIL_____
PHYSICIAN'S NAME_____
PREFERRED MEDICAL FACILITY_____
HEALTH INSURANCE CO._____POLICY#_____
IN CASE OF EMERGENCY CONTACT:

NAME_____RELATIONSHIP_____
PHONE (H)_____(W)_____(C)_____Email_____

NAME_____RELATIONSHIP_____
PHONE (H)_____(W)_____(C)_____Email_____

NAME_____RELATIONSHIP_____
PHONE(H)_____(W)_____(C)_____Email_____

CONSENT PLAN: In the event emergency medical aid/treatment is required due to illness or injury during the process of volunteering services or working for the Reinbow Riding Center, or while on the property I authorize Reinbow Riding Center to:

1. Secure and retain medical treatment and transportation if needed
2. Release volunteer records upon request of 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.

SIGNATURE_____DATE
PRINT NAME BELOW IF SIGNATURE ABOVE IS BY A PARENT OR GUARDIAN FOR A VOLUNTEER UNDER 18
_____
RELATIONSHIP_____

NON-CONSENT PLAN: I do not give my consent for emergency medical treatment/aid in case of illness or injury during the process of volunteering or working while being on the property of Reinbow Riding Center.

____ 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 to take place:
_____
_____
_____
_____

SIGNATURE_____
DATE_____
PRINT NAME BELOW IF SIGNATURE ABOVE IS BY A PARENT OR GUARDIAN FOR A VOLUNTEER UNDER 18
_____
RELATIONSHIP_____

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VOLUNTEER/STAFF: ADDITIONAL RELEASES

Dear Reinbow Riding Center Volunteer/Staff,

We may request you be a part of a Reinbow Riding Center promotional press release. We appreciate your willingness to participate in aiding us to maintain the program through such promotions. For legal reasons we require that you understand and agree to the releases below by filling them out and signing them.

Sincerely,
Reinbow Riding Center

Name: _____ Date of Birth: _____ Age: _____
Address: _____
City/State/Zip: _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____

RELEASES

I _____ do _____ do not consent to and/or authorize the use and reproduction by Reinbow Riding Center of any and all photographs and any other audio-visual materials taken of me/my son/my daughter/my ward for the promotional use, educational activities, and exhibitions or for any other use for the benefit of the program.

I _____do _____ **do not** consent to and/or authorize photos to be posted on a Social Media page such as Facebook, Twitter, etc.

I _____**do** _____ **do not** consent to and/or authorize the use of a quote to be used in promotional material and/or posted on a social media page.

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Reinbow Riding Center
CLIENT CONFIDENTIALITY

Those who work and volunteer at Reinbow Riding Center are legally bound to confidentiality. The principles which will be adhered to will include but not necessarily be limited to, the following:

- Clients will not be discussed with persons outside of the center unless the Client or his/her parent has granted written permission. Additionally, Clients will not be discussed with those involved with the Center that are not directly involved in a Client's services.
- Clients will not be discussed in public places where there is a possibility of others overhearing the conversation.
- All written information regarding Clients will be securely maintained and may not be disclosed without written parent consent or Client consent if the Client is eighteen years of age or older. Information about Clients will not be given out over the phone without specific written permission.
- Any information about Clients acquired by service providers will be kept in the strictest confidence.
- Information can be shared when reporting any suspected abuse of a Client as required by law.

Please read and sign the following document. This procedure has been developed in an effort to protect the right of confidentiality of the Clients we serve. It also serves to ensure that you are aware of the legal and moral obligation you have to maintain confidentiality.

I accept the privilege and responsibility to have access and to receive information about Clients at the Center. I understand the confidentiality of the material which I read, hear, or discuss. Under no circumstances shall I duplicate, disseminate or verbalize to unauthorized persons this information. I also understand that e-mail systems affords no expectation of privacy and is considered part of the Client's file which cannot be destroyed.

I fully understand that access to information, whether obtained from records, through my attendance at or involvement in meetings, through discussion with instructors, Clients, family members and other service providers is only for the purpose of helping me make informed choices when providing services. The information I obtain is considered personal and private and should in no way be used in a prejudicial manner.

_____
Print Name

_____ _____
Signature Date

Approved 1/9/2017

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VERMONT CRIMINAL INFORMATION CENTER
VULNERABLE POPULATIONS PROGRAM

RELEASE FORM

Qualified Entity _____

Applicant _____ _____ _____
Last First Middle

Maiden or Alias Names _____

_____

Social Security # - -

Place of Birth _____ _____ _____
City/Town State Country

Date of Birth _____ _____ _____
Month Day Year

Applicant's Phone # (include Area Code) ( ) -

RELEASE

I, _____, hereby acknowledge and agree to a check of any criminal record of convictions, which may be maintained by the Vermont Criminal Information Center. I understand that the results of the check will be made available to **Reinbow Riding Center** for use in reviewing my suitability for employment and/or as a volunteer with the program. I further understand that I have the right to appeal the results of the criminal record check to the Vermont Criminal Information Center, Department of Public Safety, 103 Main Street, Waterbury, Vermont 05671-2101.

_____ _____
Signature of Applicant Date

_____ _____
Identity Verified by Date