



2010 Volunteer Information Form

General Information

Name: _____ **Date of Birth:** _____

Telephone: _____ **Home:** _____ **Cell:** _____ **Work:** _____

Email Address: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Parent/Legal Guardian- Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Address (please circle) Work or School and provide information below:

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

How did you learn about the program? _____

Health History

Describe your current health status, particularly regarding the physical/emotional demands of working in a therapeutic riding program. Please address fitness, cardiac, respiratory, bone or joint function, recent hospitalizations/surgeries or lifestyle changes.

Allergies: _____

Medications: _____

Recent medical tests: Last Tetanus Shot: _____ Date: _____

Tuberculosis Test: + or - Date: _____

Photo Release

I, the volunteer ACCEPT or DECLINE consent to and authorize the use of and reproduction by Partners for Progress 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 program.

Signature: _____

I agree that the information provided in this form 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: _____

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Emergency Medical Treatment-----

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, I authorize Partners for Progress to secure and retain medical treatment and transportation if needed.

Volunteer Name: _____

Emergency Contact: _____

Telephone: _____

Telephone: _____

Physician Name: _____

Telephone: _____

Preferred Medical Facility: _____

Health Insurance Co: _____

Policy #: _____

Please select the Consent Plan or the Non-Consent Plan in the case of an emergency

Consent Plan

This authorization includes x-ray, surgery, hospitalization, medication, and any other treatment procedure deemed "live saving" by the physician. This provision will only be invoked if we are unable to reach the emergency contacts.

Print Consent Name: _____

Consent Signature: _____

Date: _____

Volunteer, Parent or Guardian

Non-Consent Plan

I do not give my consent for emergency medical aid/treatment in the case of illness or injury during the process of receiving services or while being on the property of the agency. In the event that emergency aid/treatment is required, I wish the following procedures to take place:

Print Non-Consent Name: _____

Non-Consent Signature: _____

Date: _____

Volunteer, Parent or Guardian