Equine Dreams

Volunteer/Staff Information Form and Health History

General Information

Name: _____ Date: _____

Address: _____City/State/Zip_____

DOB: _____ Email address: _____

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

Please identify your race and ethnicity below: *(Information is used for grant reporting purposes.)*

- ☐ African American/Black
- ☐ Asian/Pacific Islander
- ☐ Caucasian/White, Non-Hispanic
- ☐ Hispanic/Latino
- ☐ Native American/American Indian
- ☐ 2 or more races
- ☐ Other - Please specify: _____

☐ please check if you are a Veteran

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-if you are not up to date, we recommend strongly that you are current before you begin volunteering.)

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: _____

_____
Initials of Participant or Guardian

Check which areas you are interested in:

Program	Special Events	Administration	
☐ Horse handling	☐ Horse shows	☐ Public relations	☐ Photography
☐ Side walking	☐ Fundraising	☐ Grant writing	☐ Budget/Finance
☐ Stable Mgmt.	☐ Special Olympics	☐ Newsletter	☐ Future planning
☐ Facility repairs	☐ Trail rides	☐ Volunteer Recruitment	

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: _____

Volunteer, Staff, Parent, Caregiver or Legal Guardian

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: _____

Volunteer, Staff, Parent, Caregiver or Legal Guardian

BACKGROUND INFORMATION

Have you ever been charged with or convicted of a crime; including sex-related or child-abuse related offenses?
Y N please explain _____

_____

Equine Dreams reserves the right to perform a fingerprint background check on all volunteers at any time.
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 _____

*****If you have had a background check completed within the last year, please copy and submit with this application.**

_____

Initials of Participant or Guardian

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 Head Instructor.
- 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.

_____ _____

Volunteer, Staff, Parent, Caregiver or Legal Guardian **Date**

_____

Initials of Participant or Guardian

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.

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: _____

Volunteer, Staff, Parent, Caregiver 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.

Date: _____ Non-Consent Signature: _____

Volunteer, Staff, Parent, Caregiver 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 and of driving horses or ponies. **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. Under Illinois law, an equine activity sponsor or professional shall not be liable for any injury to, or the death of a participant in equine activities resulting from the inherent risk of equine activities. I acknowledge the risks and potential for risks of horseback riding and related equine activities involving equines and/or farm animals.** 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: _____

Volunteer, Staff, Parent, Caregiver or Legal Guardian

_____

Signature of staff confirms witness of all signatures on volunteer paperwork

_____

Initials of Participant or Guardian

Equine Dreams, Inc.

Release and Hold Harmless Agreement

WHEREAS, the UNDERSIGNED acknowledges the inherent risks involved in riding and working around horses, these risks include bodily injury from using, riding or being in close proximity to horses, among other risks, and further, that both horses and rider can be injured in normal use or in competition and schooling.

IN CONSIDERATION, therefore, for the privilege of riding and/or working around horses at Equine Dreams, Inc., located at 9775 Fox River Drive, Newark, IL 60541, the undersigned does hereby agree to hold harmless and indemnify Equine Dreams Inc. and further release them from any liability or responsibility for accident, damage, injury, or illness to the Undersigned or any horse owned by the Undersigned or to any family member or spectator accompanying the Undersigned while on the premises of Equine Dreams Inc. and that except in the event of this stables gross and willful negligence, I shall bring no claims, demands, actions and causes of action, and/or litigation, against this stable for any economic and non-economic losses due to bodily injury, death, and/or property damage sustained by me and/or my minor child or legal ward in relation to the premises and operations of this stable, including while riding, hauling, lessons, adopting horses, shows, activities, trailering, etc.

Date: _____

Signature: _____

Signature of Parent or Guardian: _____

Print Name: _____

Address: _____

Witness Signature: _____

Witness Print Name: _____

P.O. Box 372, Sandwich, IL 60548
www.equinedreams.org

_____
Initials of Participant or Guardian

Equine Dreams Therapeutic Riding Center Rules
Welcome Volunteers, Parents and Students!

We'd like to remind you of our barn rules:

- Parents, family members, and guests, **please remember to stay in the parent viewing area, behind the white fence, unless specifically asked or invited by staff to come to the arena area.**
- **Please refrain from engaging in conversation with your child or any riders during their lesson time. This can be extremely distracting to students, staff and volunteers who may need to listen for important lesson and safety instructions.**
- No smoking.
- Everyone must wear a helmet when riding.
- No running or yelling.
- No dogs allowed (except assistance dogs).
- All riders are required to use safety Peacock stirrups or Western Sidestep Break- away stirrups.
- Everyone is required to wear fully enclosed shoes.
- Children must be under adult supervision at all times.
- All horse areas are off limits.
- Do not feed the horses by hand.
- All horse paddocks, stalls and fields are off-limits.
- No one is allowed on this property without the presence/supervision of an Equine Dreams registered riding instructor and/or a designated staff member.
- No activities are to be performed on this property after dark.
- No equine assisted activity on this property without the supervision of a PATH Intl. registered riding instructor.

_____

Initials of Participant or Guardian

Authorization to Release Information Concerning Background

The undersigned has applied to volunteer with Equine Dreams. As part of the application process, I authorize Equine Dreams to complete a criminal background check on me through the Kendall County Sheriff's Office and/or the Illinois State Police. I also authorize Equine Dreams to verify my past employment history and to check my personal and professional references. I hereby authorize any person to release any and all information necessary for Equine Dreams and/or the Kendall County Sheriff's Office to complete the above-referenced investigation. I certify that I will not hold Equine Dreams, the Kendall County Sheriff's Office, Kendall County and/or their respective board members, elected officials, judges, insurers, officers, employees, agents, and/or assigns liable in any way in connection with this investigation. I understand and agree that, to the extent permitted by applicable state and federal laws, falsification of any information provided by me and/or the results of the background check may be immediate grounds to deny my application to volunteer and/or may result in the immediate termination of my volunteer status with Equine Dreams. The original of this authorization shall remain on file with Equine Dreams and shall be valid for a period of three (3) years from the date subscribed below. I specifically authorize the release of any information requested and agree that a photocopy of this release shall have the same validity as an original copy.

(Note: All Fields Must Be Filled Out)

Dated this _____ day of _____, 20____

Print Name: _____
First Middle Initial Last

Address: _____
Street

_____
City State Zip

Date of Birth: _____

Signature: _____
(Note: If applicant is a minor under the age of 18, this form must be signed by a legal guardian)

_____
Initials of Participant or Guardian