



# Equine Dreams

## Volunteer/Staff Information Form and Health History

### General Information

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ City/State/Zip \_\_\_\_\_

County: \_\_\_\_\_ 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.

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Allergies: \_\_\_\_\_

Medications: \_\_\_\_\_

**Check which areas you are interested in:**Program

- Horse handling  
 Side walking  
 Stable Mgmt.  
 Facility repairs

Special Events

- Horse shows  
 Fundraising  
 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: \_\_\_\_\_

**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**

**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: \_\_\_\_\_

Witness Signature: \_\_\_\_\_

Witness Print Name: \_\_\_\_\_

# EQUINE DREAMS CONFIDENTIALITY STATEMENT

Please check the appropriate box.

New Help Introduction

Volunteer

Physician / PA / Intern / Resident

Physician Practice Personnel

Employee / Student / Agency

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**

**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

## **Equine Dreams Therapeutic Riding Center Rules**

### **Welcome Volunteers, Parents and Students!**

**(This is for the volunteer to keep)**

**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.