



# Equine Dreams

## Volunteer/Staff Information Form and Health History

### General Information

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

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

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.

---

---

---

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 staff to make a copy of this form to give to the volunteer****BACKGROUND CHECK DISCLOSURE**

Equine Dreams, (the “Company”) may order a “consumer report” (a background report) or “investigative consumer report” on you in connection with your volunteer application, and if you are accepted as a volunteer, or if you already volunteer for the Company, may order additional background reports on you for volunteer purposes, to the maximum extent permitted by applicable law. The background check company, ADP Screening and Selection Services, will prepare the background report for the Company. ADP Screening and Selection Services is located at 301 Remington Street, Fort Collins, CO, 80524, and can be reached by phone at 800-367-5933 or at their Internet Web site address [www.adpselect.com](http://www.adpselect.com). The background report may contain information concerning your character, general reputation, personal characteristics, mode of living, criminal history, and credit standing. An “investigative consumer report” is a background report that includes information from personal interviews. Information may be obtained from private and public sources and for investigative consumer reports from personal interviews as noted above. You may request more information about the nature and scope of an investigative consumer report, if any, by contacting the Company. The Fair Credit Reporting Act gives you specific rights in dealing with consumer reporting agencies. You will find these rights summarized in the document titled A Summary of Your Rights Under the Fair Credit Reporting Act, as provided on subsequent pages.

**Authorization for Background Checks**

I authorize the Company to obtain my background report, including investigative consumer reports. I also agree that a copy of this form is valid like the signed original. I understand that, as allowed by law, the Company may rely on this authorization to order additional background reports, including investigative consumer reports, (1) during my time as a volunteer and (2) from companies other than ADP Screening and Selection Services without asking me for my authorization again, as allowed by law. I understand the Company may order a background report under my legal name and any other names I may have used.

I also authorize the following agencies and entities to disclose to ADP Screening and Selection Services and its agents all information about or concerning me, as allowed by law, including but not limited to: my past or present employers; learning institutions, including colleges and universities; law enforcement and all other federal, state and local agencies; federal, state and local courts; the military; credit bureaus; testing facilities; motor vehicle records agencies; if applicable, worker’s compensation injuries; all other private and public sector repositories of information; and any other person, organization, or agency with any information about or concerning me. The information that can be disclosed to ADP Screening and Selection Services and its agents includes, but is not limited to, information concerning my employment history, earnings history, education, credit history, motor vehicle history, criminal history, military service, professional credentials and licenses and substance abuse testing.

Please print your legal name:

Last Name \_\_\_\_\_ First \_\_\_\_\_ Middle \_\_\_\_\_

\_\_\_\_\_  
Signature

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date (Month/Day/Year)

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

**BACKGROUND CHECK INFORMATION**

The information requested below is collected solely for the purpose of aiding the Company in running a background check in connection with your application for your volunteer work. The organization is requesting that you provide this information to assist in conducting a thorough background check.

First Name \_\_\_\_\_ Middle Name \_\_\_\_\_ Last Name \_\_\_\_\_

For Identification Purposes Only: Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ (Month/Day/Year)

Social Security Number \_\_\_\_\_

Driver's License Number \_\_\_\_\_ State Issuing License \_\_\_\_\_

Enter Nickname(s) Used \_\_\_\_\_

Enter Any Other Names Used (including maiden names):

First Name \_\_\_\_\_ Middle Name \_\_\_\_\_ Last Name \_\_\_\_\_

First Name \_\_\_\_\_ Middle Name \_\_\_\_\_ Last Name \_\_\_\_\_

First Name \_\_\_\_\_ Middle Name \_\_\_\_\_ Last Name \_\_\_\_\_

Addresses within the Past Seven Years (use a separate sheet as needed)

Present Street Address \_\_\_\_\_

City/State/ZIP \_\_\_\_\_

Prior Street Address \_\_\_\_\_

Prior City/State/ZIP \_\_\_\_\_

From \_\_\_\_/\_\_\_\_/\_\_\_\_ (Month/Day/Year) To \_\_\_\_/\_\_\_\_/\_\_\_\_ (Month/Day/Year)

**(\*\*This page will be shred after the background check received)**

## **\*\*Volunteer to keep the following 3 pages.**

*Para informacion en espanol, visite [www.consumerfinance.gov/learnmore](http://www.consumerfinance.gov/learnmore) o escribe a la Consumer Financial Protection Bureau, 1700 G Street N.W., Washington, DC 20552.*

### **A Summary of Your Rights Under the Fair Credit Reporting Act**

The federal Fair Credit Reporting Act (FCRA) promotes the accuracy, fairness, and privacy of information in the files of consumer reporting agencies. There are many types of consumer reporting agencies, including credit bureaus and specialty agencies (such as agencies that sell information about check writing histories, medical records, and rental history records). Here is a summary of your major rights under the FCRA. **For more information, including information about additional rights, go to [www.consumerfinance.gov/learnmore](http://www.consumerfinance.gov/learnmore) or write to: Consumer Financial Protection Bureau, 1700 G Street N.W., Washington, DC 20552.**

- **You must be told if information in your file has been used against you.** Anyone who uses a credit report or another type of consumer report to deny your application for credit, insurance, or employment – or to take another adverse action against you – must tell you, and must give you the name, address, and phone number of the agency that provided the information.
- **You have the right to know what is in your file.** You may request and obtain all the information about you in the files of a consumer reporting agency (your “file disclosure”). You will be required to provide proper identification, which may include your Social Security number. In many cases, the disclosure will be free. You are entitled to a free file disclosure if:
  - a person has taken adverse action against you because of information in your credit report;
  - you are the victim of identity theft and place a fraud alert in your file;
  - your file contains inaccurate information as a result of fraud;
  - you are on public assistance;
  - you are unemployed but expect to apply for employment within 60 days.

In addition, all consumers are entitled to one free disclosure every 12 months upon request from each nationwide credit bureau and from nationwide specialty consumer reporting agencies. See [www.consumerfinance.gov/learnmore](http://www.consumerfinance.gov/learnmore) for additional information.

- **You have the right to ask for a credit score.** Credit scores are numerical summaries of your credit-worthiness based on information from credit bureaus. You may request a credit score from consumer reporting agencies that create scores or distribute scores used in residential real property loans, but you will have to pay for it. In some mortgage transactions, you will receive credit score information for free from the mortgage lender.
- **You have the right to dispute incomplete or inaccurate information.** If you identify information in your file that is incomplete or inaccurate, and report it to the consumer reporting agency, the agency must investigate unless your dispute is frivolous. See [www.consumerfinance.gov/learnmore](http://www.consumerfinance.gov/learnmore) for an explanation of dispute procedures.
- **Consumer reporting agencies must correct or delete inaccurate, incomplete, or unverifiable information.** Inaccurate, incomplete or unverifiable information must be removed or corrected, usually within 30 days. However, a consumer reporting agency may continue to report information it has verified as accurate.
- **Consumer reporting agencies may not report outdated negative information.** In most cases, a consumer reporting agency may not report negative information that is more than seven years old, or bankruptcies that are more than 10 years old.
- **Access to your file is limited.** A consumer reporting agency may provide information about you only to people with a valid need -- usually to consider an application with a creditor, insurer, employer, landlord, or other business. The FCRA specifies those with a valid need for access.
- **You must give your consent for reports to be provided to employers.** A consumer reporting agency may not give out information about you to your employer, or a potential employer, without your written consent given to the employer. Written consent generally is not required in the trucking industry. For more information, go to [www.consumerfinance.gov/learnmore](http://www.consumerfinance.gov/learnmore).
- **You may limit “prescreened” offers of credit and insurance you get based on information in your credit report.** Unsolicited “prescreened” offers for credit and insurance must include a toll-free phone number you can call if you choose to remove your name and address from the lists these offers are based on. You may opt-out with the nationwide credit bureaus at 1-888-567-8688.
- **You may seek damages from violators.** If a consumer reporting agency, or, in some cases, a user of consumer reports or a furnisher of information to a consumer reporting agency violates the FCRA, you may be able to sue in state or federal court.
- **Identity theft victims and active duty military personnel have additional rights.** For more information, visit [www.consumerfinance.gov/learnmore](http://www.consumerfinance.gov/learnmore).

**States may enforce the FCRA, and many states have their own consumer reporting laws. In some cases, you may have more rights under state law. For more information, contact your state or local protection agency or your state Attorney General. For information about your federal rights, contact:**

| TYPE OF BUSINESS:  | CONTACT:   |
|--|--|
| <p>1.a. Banks, savings associations, and credit unions with total assets of over \$10 billion and their affiliates.</p> <p>b. Such affiliates that are not banks, savings associations, or credit unions also should list, in addition to the CFPB:</p>  | <p>a. Consumer Financial Protection Bureau<br/>1700 G Street, N.W.<br/>Washington, DC 20552</p> <p>b. Federal Trade Commission: Consumer Response Center – FCRA<br/>Washington, DC 20580<br/>(877) 382-4357</p>  |
| <p>2. To the extent not included in item 1 above:</p> <p>a. National banks, federal savings associations, and federal branches and federal agencies of foreign banks</p> <p>b. State member banks, branches and agencies of foreign banks (other than federal branches, federal agencies, and Insured State Branches of Foreign Banks), commercial lending companies owned or controlled by foreign banks, and organizations operating under section 25 or 25A of the Federal Reserve Act</p> <p>c. Nonmember Insured Banks, Insured State Branches of Foreign Banks, and insured state savings associations</p> <p>d. Federal Credit Unions</p> | <p>a. Office of the Comptroller of the Currency<br/>Customer Assistance Group<br/>1301 McKinney Street, Suite 3450<br/>Houston, TX 77010-9050</p> <p>b. Federal Reserve Consumer Help Center<br/>P.O. Box 1200<br/>Minneapolis, MN 55480</p> <p>c. FDIC Consumer Response Center<br/>1100 Walnut Street, Box # 11<br/>Kansas City, MO 64106</p> <p>d. National Credit Union Administration<br/>Office of Consumer Protection (OCP)<br/>Division of Consumer Compliance and Outreach (DCCO)<br/>1775 Duke Street<br/>Alexandria, VA 22314</p> |
| <p>3. Air carriers</p>   | <p>Asst. General Counsel for Aviation Enforcement &amp; Proceedings<br/>Aviation Consumer Protection Division<br/>Department of Transportation<br/>1200 New Jersey Avenue, S.E.<br/>Washington, DC 20590</p>   |
| <p>4. Creditors Subject to the Surface Transportation Board</p>  | <p>Office of Proceedings, Surface Transportation Board<br/>Department of Transportation<br/>395 E Street, S.W.<br/>Washington, DC 20423</p>  |
| <p>5. Creditors Subject to the Packers and Stockyards Act, 1921</p>  | <p>Nearest Packers and Stockyards Administration area supervisor</p>   |
| <p>6. Small Business Investment Companies</p>  | <p>Associate Deputy Administrator for Capital Access<br/>United States Small Business Administration<br/>409 Third Street, SW, 8<sup>th</sup> Floor<br/>Washington, DC 20416</p>   |
| <p>7. Brokers and Dealers</p>  | <p>Securities and Exchange Commission<br/>100 F Street, N.E.<br/>Washington, DC 20549</p>  |
| <p>8. Federal Land Banks, Federal Land Bank Associations, Federal Intermediate Credit Banks, and Production Credit Associations</p>  | <p>Farm Credit Administration<br/>1501 Farm Credit Drive<br/>McLean, VA 22102-5090</p>   |
| <p>9. Retailers, Finance Companies, and All Other Creditors Not Listed Above</p>   | <p>FTC Regional Office for region in which the creditor operates <u>or</u><br/>Federal Trade Commission: Consumer Response Center – FCRA<br/>Washington, DC 20580<br/>(877) 382-4357</p>   |



## **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.