HEALING STRIDES VOLUNTEER APPLICATION

Return to PO Box 456, Boones Mill, VA 24065

Name: _____ Date: _____

Street: _____

City: _____ State: _____ Zip: _____Email_____

Home Phone:_____ Work:_____ Cell:_____

Occupation: (if student, what year/major):_____

Parents/Guardian/Spouse: _____ Phone:_____

Street:_____City:_____State:_____ Zip:_____

Volunteer Liability Release

As a volunteer with Healing Strides of VA, I acknowledge and understand the risks and potential risks of a horseback riding program including but not limited to, (i) the propensity of an equine to behave in dangerous ways, which may result in injury or death to the participant or damage to property; (ii) the inability to predict an equine's reaction to sound, movements, objects, persons or animals; (iii) hazards of surface or subsurface conditions whether known or unknown; (iv) the condition and age of the equipment or tack, however, I feel that the possible benefits to myself and the clients I work with are greater than the risk I assume. I hereby, intent to be legally bound, for myself, my heirs and assigns, executors or administrators, and waive and release forever all claims for damages against- Healing Strides of VA (formerly The Roanoke Valley Therapeutic Riding Program, Inc.), their board of directors, instructors, therapists, aides, volunteers, employees and their respective families, for any and all injuries and/or losses I may sustain while participating in Healing Strides of VA. I further certify that the foregoing statements and representations are being made by me knowingly, freely and voluntarily, and I understand that Healing Strides of VA is expressly relying upon the foregoing statements and representations in permitting me to participate in Healing Strides of VA.

Signature: _____ Date_____
Parent/Guardian: _____Date_____

Photo release (must initial)

____I consent to and authorize the use and reproduction by Healing Strides of VA any and all photographs and any other audiovisual materials taken of me for promotional material, educational activities, exhibitions, or for any other use for the benefit of the program.

____ I do **not** consent to the above photo release.

Signature: _____Date_____
Parent/Guardian: _____Date_____

11/30/2018

Office Use Only
Date Entered: _____

Authorization for Emergency Medical Treatment Form

In the event emergency medical aid/treatment is required due to illness or injury during the process of receiving/giving services, or while being on the property of the agency or boarding facility, I authorize Healing Strides of VA 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.

Name: _____Phone: _____Cell/work: _____

Address: _____ In the event an emergency occurs, please contact:

Contact/relation: _____Phone:_____

Contact/relation: _____Phone: _____

Allergies: _____

Physician's Name: _____Phone: _____ Preferred Medical Facility:

_____

Health Insurance Co. :* _____

Policy #: _____

**If readily available*

Consent Plan

This authorization includes X-ray, hospitalization, medication and any treatment procedure deemed "life saving" by the physician. This provision will only be invoked if the person consenting below is non-responsive in a medical emergency.

Date: _____Consent Signature:_____

Client, Volunteer, Parent or Guardian

Print Name: _____

Name _____

(please print)

Healing Strides of VA Confidentiality Policy
And
Volunteer/Intern Agreement

- Due to the nature of Healing Strides' program, we are entrusted with sensitive personal information. Our clients are entitled to assurance of protection from unwarranted invasion of personal privacy. The Privacy Act, State and Federal Laws, regulations from licensing agencies and our basic constitutional rights are designed to protect us all from unwarranted invasion of privacy.

- No information about a client, including enrollment or residence, in written or any other form, may be disclosed to any person or organization without proper authorization. (The only exception is in a life-threatening emergency, in which necessary medical information may be disclosed to emergency personnel to expedite treatment). Healing Strides staff is responsible for reviewing all requests for information to ensure that the proper authorization has been obtained.

- Again, our records contain sensitive client information, which is protected by law from unauthorized disclosure. Healing Strides holds the moral and legal obligation to protect the interests of both our clients and employees. By signing the confidentiality agreement at it shall represent each volunteer/intern's commitment to protect the privacy of our clients, both past and present.

- I have read the above and agree to maintain this policy during and after my tenure with Healing Strides. I realize that this document will become a permanent part of my Volunteer/Intern File. I further realize that failure to comply with the policies on confidentiality could result in formal reprimand or termination of position, depending on the circumstances involved.

_____ _____

Healing Strides of VA Volunteer/Intern Date

Healing Strides of VA Administrator Date

Please circle areas in which you would like to assist:

Special Event Volunteer
Therapeutic Riding
Internship
Barn Help
Office Help

Please list horse experience. This is NOT a requirement for volunteering!

Please list any experience with kids or adolescence both able bodied and disabled populations. Again, this is not a requirement!