



Parkwood Farms Therapy Center

2519 Parkwood Road

Snellville, GA 30039-4403

678-344-6821 770-985-8758

Volunteer Information Form

Name: _____ HomePhone: _____

Address: _____ City: _____ State: _____ ZIP: _____

Cell Phone: _____ Work Phone: _____ DOB: _____

Email Address _____

If student, name of school: _____

How did you learn about **Parkwood Farms Therapy Center**: _____

Check which areas you are interested in:

Program Volunteer

- Leading a horse
- Side Walking w/ student
- Stable management
- Facility Repairs

Competition

- Horse Show
- Away Horse Show
- Ride-A-Thon
- Special Olympics
- Trail Rides

Administration

- Public Relations
- Grant Writing
- Fund Raising
- Newsletter
- Volunteer Recruitment
- Photography/Video
- Budget and Finance
- Future Planning

In Case of Emergency

Name: _____ Home Phone: _____ Work Phone _____

Address: _____

Physican: _____ Phone: _____

Hospital and Town: _____

In case of emergency, I give permission to **Parkwood Farms Therapy Center** to secure medical treatment including x-rays, surgery, hospitalization, and medication.

Date: _____ Signature: _____

Volunteer Liability Release

As a volunteer at Parkwood Farms Therapy Center, I acknowledge the risks and potential for risks of a horseback riding program. However, I feel that the possible benefits to myself and the clients I work with are greater than the risk assumed. I hereby, intending to be legally bound, for myself, my heirs, and assigns, executors or administrators, waive and release forever all claims for damages against **Parkwood Farms Therapy Center**, its owners, instructors, Therapist, volunteers and/or employees for any and all injuries and/or losses I may sustain while participating with/in **Parkwood Farms Therapy Center**.

Date: _____ Signature: _____



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Authorization for Emergency Medical Treatment Form

Staff

Participant

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: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

In the event emergency medical aid/treatment is required due to illness or injury during the process of participating in services, or while being on the property of **Parkwood Farms Therapy Center** and its' owners, I authorize **Parkwood Farms Therapy Center** 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.

Consent Plan

This authorization includes x-ray, surgery, hospitalization, medication, and any treatment procedures 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: _____

Client, Parent, or Legal Guardian
Signed in the presence of center staff

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 on the property of **Parkwood Farms Therapy Center**. In the event emergency treatment/ aid is required, I wish the following procedures to take place:

Date: _____ Consent Signature: _____

Client, Parent, or Legal Guardian
Signed in the presence of center staff

A COPY OF THE COMPLETED MEDICAL/HEALTH HISTORY SHOULD BE ATTACHED TO THIS FORM.



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Volunteer /Staff Information and Health Form

General Information

Name: _____ Date: _____
 Address: _____
 Employer/School: _____
 Address: _____ Date of Birth: _____
 Phone: (H) _____ (W) _____
 Parent/Legal Guardian Name and Address: _____
 _____ How did you hear about the program? _____
 Recent medical tests: Last Tetanus Shot: _____ Tuberculosis Test + - Date: _____
 (Consult your physician or local health department if you are not up to date with these shots/tests)

Health History

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

Allergies: _____

Medications: _____

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 **Parkwood Farms Therapy Center's** program.

Signature: _____ Date: _____
(Volunteer/staff; signed in presence of center staff)



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Volunteer/Staff Form and Health History

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Name: _____

Address: _____

Phone: (H) _____ (W) _____ Date of Birth: _____

Photo Release

- I DO
- DO NOT

consent to and authorize the use and reproduction by **Parkwood Farms Therapy Center** of any and all photographs and any other audio/visual materials taken of me for promotional materials, educational activities, exhibitions, or for any other use for the benefit of the program.

Signature: _____ Date: _____

Background Information

Have you ever been charged with or convicted of a crime? **Y N** ; please explain: _____

I, _____ (volunteer/staff), authorize **Parkwood Farms Therapy Center** to receive information from any law enforcement agency, including police departments and sheriff's departments, of this state or any other state or federal governments, to the extent permitted by state and federal law, pertaining to any conviction I may have had for violations of state or federal criminal laws, including but not limited to convictions for crimes committed upon children.

I understand that such access is for the purpose of considering my application as an employee/volunteer, and that I expressly **DO NOT** authorize the NARHA center, its owners, employees, or other volunteers to disseminate this information in any way to any other individual, group, agency, organization, or corporation.

Signature: _____ Date: _____
(volunteer/staff)

CURRENT DRIVER'S LICENSE **Y N** LICENSE NUMBER _____ STATE _____

Confidentiality Agreement

I understand that all information (written and verbal) about participants at this NARHA center is confidential and will not be shared with anyone without the express written consent of the participants and their parent/guardian in the case of a minor.

Signature: _____ Date: _____
(volunteer/staff)