



Volunteer Sign Up Package

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PO Box 138
Waimanalo, Hi 96795



RELEASE AGREEMENT
THERAPEUTIC HORSEMANSHIP of HAWAII, INC.
AND CONTRIBUTORS

I, the undersigned, understand that Hawaii Law (Act 249, 1994 Hawaii Legislative Session, effective June 29, 1994) limits the civil liability of persons sponsoring equine (horse, pony, mule, donkey, or hinney) activities. I understand that there are inherent risks of injury, including death, when participating in an equine activity, which risks included but are not limited to (1) the propensity of an equine to behave in ways that may result in injury or death to persons on or around them, (2) the predictability of an equine's reaction to such things as sounds, sudden movement and unfamiliar objects, persons or object animals, (3) hazards such as surface and sub-surface conditionals, (4) collisions with other equine or objects, and (5) the potential negligence of another participant, such as failing to maintain control over the equine, or not acting within the participant's ability. Knowing and understanding the risks of participating in an equine activity; including injury and death to my person and damage to my personal property, I expressly choose to assume these risks. Further, on behalf of myself, my heirs, successors, representative, and assigns, I hereby unconditionally release any and all claims and causes of actions against equine activity sponsor Therapeutic Horsemanship of Hawaii and the Honolulu Polo Club, and it/theirs owners, shareholders, officers, directors, principals, employees, agents, representatives and any other personnel, for injury including death, and for any damage to personal property, which I may incur as a result of my participation in this equine activity. If the undersigned agrees to indemnify the above-described equine activity sponsor (including its/their above-described persons and entities) from any and all claims and causes of action brought by or on behalf of said participant at any time.

DATE: _____

Volunteer Name: _____ SIGNATURE: _____
IF UNDER 18 YEARS OF AGE A PARENT OR GUARDIAN MUST SIGN

Parent Name: _____



Volunteer Information Sheet

Name: _____ Date: _____

Phone: _____ Cell: _____

Email: _____

Please add me to the THH email update list for upcoming events (promise no more than one email per week!!)

Mailing Address: _____

Days of the week available; Mon Tues Wed Fri Sat Sun

Hours available: _____ to _____

I am over the age of 18

I am under the age of 18

Please describe experience with horses: _____

Please describe experience with children or individuals with special needs:

Authorization for Emergency Medical Treatment Form

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 Therapeutic Horsemanship of Hawaii 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-ray, 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: _____

Client, Parent 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 the agency.

- Parent or legal guardian will remain on site at all times during equine assisted activities.
- In the event emergency treatment/aid is required, I wish the following procedure to take place:

Date: _____ Non-Consent Signature: _____

Client, Parent or Legal Guardian

Volunteer/Staff Information Form and Health History

General Information

Date of Birth: _____

Employer/School: _____

Parent/Legal Guardian/Caregiver Name/Address/Phone Number: _____

How did you learn 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 an equine assisted program. Address fitness, cardiac, respiratory, bone or joint function, recent hospitalizations/surgeries, or lifestyle changes.

Allergies: _____

Medications: _____

Check areas in which you are interested:

Program

Horse Handling

Sidewalking with a Student

Stable Management

Facility Repairs

Special Events

Horse Show

Fundraising

Administration

Public Relations

Grant Writing

Newsletter

Volunteer Recruitment

Photography/Video

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 this center's program.

Signature: _____ Date: _____

(volunteer/staff/caregiver)

Volunteer/Staff Information Form and Health History -

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Name: _____

Address: _____

Phone: _____ Date of Birth: _____

Photo Release

I DO

DO NOT (A "Do Not" answer will prevent you from participating in any events with our program)

consent to and authorize the use and reproduction by Therapeutic Horsemanship of Hawaii of any and all photographs 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: _____

Background Information

Have you ever been charged with or convicted of a crime? Y N Please explain _____

I, _____ (volunteer/staff), authorize _____
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 I expressly DO NOT authorize the NARHA center, 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: _____

(volunteer/staff)

Confidentiality Agreement

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

Signature: _____ Date: _____

(volunteer/staff)