P.O. Box 551
Bath, Ohio 44210
Phone (330) 666-0300
Fax (330) 668-6068

VOLUNTEER/STAFF INFORMATION FORM AND HEALTH HISTORY

Name _____ **Birth Date**_____

Address _____ **City** _____ **Zip** _____

Parent/Legal Guardian Name and Address _____

_____

Home Phone _____ **Work Phone** _____ **Cell Phone** _____

Commitment Level? Weekly _____ As Needed _____Temporary (fulfilling community service hours) _____

Do you have experience with horses? _____ If so, please specify _____

_____

Do you have any other skills or training, which may be of benefit to a volunteer program? _____

_____

How did you find out about Victory Gallop? _____

_____ YES, I received and read the Victory Gallop Volunteer Handbook.

HEALTH HISTORY

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

_____

_____

_____

_____

_____

Allergies _____

Medications _____

Last Tetanus Shot: _____ Tuberculosis Test + -- Date: _____

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; signed in presence of center staff)

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VOLUNTEER/STAFF INFORMATION

Name: _____
Please Print

PHOTO RELEASE

I _____ DO

_____ DO NOT

consent to and authorize the use and reproduction by Victory Gallop of any and all photographs and any other audio/visual materials taken of me/my son/my daughter/my ward for promotional printed 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? Yes _____ No _____

If yes, please explain _____

_____

_____

I, _____, authorize Victory Gallop 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.

I understand that such access if for the purpose of considering my application as an employee/volunteer, and that 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: _____

Current Driver's License Y N License Number _____ State _____

CONFIDENTIALITY AGREEMENT

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

Signature: _____ Date: _____

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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: _____

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 Victory Gallop, Inc. and/or the David M. and Susan J. Miller Irrevocable Trust, I authorize **Victory Gallop, Inc. and any of its representatives** to:

1. Secure and retain medical or dental treatment and transportation if needed; and
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 diagnostic treatment procedure deemed "life saving" or necessary to preserve well being by the physician and/or dentist, as the case may be. 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 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 being on the property of the agency. In the event that emergency treatment/aid is required, I wish the following procedures to take place:

_____

_____

_____

_____

Date: _____ Consent Signature: _____

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

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

VICTORY GALLOP

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LIABILITY RELEASE

***Please read the following carefully. You are being asked to release us of all liability*.**

This hereby acknowledges that _____ (print name) (sometimes hereafter referred to as the "Participant"), is applying for registration to participate in the horseback riding and training program and/or any other horse related activities associated with horses and stables (the "Activities") conducted by Victory Gallop, Inc. (the "Program") on or about the premises owned and/or operated by Victory Gallop, Inc. and The David M. and Susan J. Irrevocable Trust. I fully understand that the Program's Activities involve exercise and personal body contact, and that there are risks and dangers to the Participant and to others inherent in the Activities including, but not limited to, bodily injury, disability, paralysis and death. I also understand that there are other risks not known or foreseeable at this time that could arise.

I hereby agree to assume and accept all risks of injury, illness or damage that might be sustained while Participant participates in or observes the Program, and in consideration for Participant being allowed to participate in the Program, I hereby forever release and fully discharge Victory Gallop, Inc., its agents, employees, instructors, guest instructors, therapists, aides, volunteers, members, trustees, guests and other participants, as the case may be, including but not limited to the David M. and Susan J. Miller Irrevocable Trust, David Miller, Susan Miller, and Kimberly Gustely (collectively, the "Released Parties"), from and for any and all liability, injuries, damages, claims, demands or actions in any way arising out of or related to Participant's participation in the Activities. I also agree to indemnify and hold harmless the Released Parties for and from any and all claims, liabilities, expenses, judgments, costs, and losses of any kind, including reasonable attorney's fees, which may be incurred in connection with any action brought against them as a result of the Participant's participation in the Program. I hereby authorize physicians, dentists, and staff, duly licensed as doctors of medicine or doctors of dentistry or other such licensed technicians or nurses, to perform any diagnostic procedures, treatment, operative procedures, and x-ray treatment in the event of Participant's injury, accident and/or illness during participation in the Program. Participant will bear the full cost and burden of such treatment.

Participant will strictly abide by the rules of the Program and strictly follow all instructions given during the course of participation. Should Participant break any of these rules or instructions, it is the decision of the Victory Gallop, Inc. whether or not Participant may continue in the Program, and Participant will abide by that decision.

This agreement is made on behalf of Participant and his or her heirs, successors, assigns, executors, estate and personal representatives, of any nature, and I understand and agree that it is and will be binding on them as well as Participant.

If Participant is 18 or over: In signing this agreement I am stating that I am a legally competent adult 18 years of age or older, I have read carefully and understand the terms of this agreement and release, I fully agree to each of the statements and terms contained herein, and I am signing as my own free act with the intention to be legally bound thereby.

_____ _____

Signature Date

If Participant is under 18: I, the undersigned, am the parent or legal guardian of the above Participant and consent to allow the applicant to participate in the Program on the terms and conditions set forth above. I have carefully read and understood each of the terms of this agreement and release, I fully agree to each of the statements and terms contained herein, and I am signing as my own free act with the intention to legally bind myself, the Participant, and all heirs, successors, assigns, executors, estates and personal representatives, of any and every nature, of both the Participant and myself, to all of the terms hereof.

_____ _____

Signature of Parent or Guardian Date

WARNING! BY SIGNING THIS RELEASE YOU ARE GIVING UP YOUR RIGHTS TO SUE OR OTHERWISE RECOVER DAMAGES FROM THE RELEASED PARTIES REGARDLESS OF ANY NEGLIGENCE, WRONGDOING OR FAULT OF THE RELEASED PARTIES.