2025 Hope on Horseback
Therapeutic Riding Center
Volunteer Information and Release Form

Please print clearly

Office Only:	
Name Tag	____
Database	____
Email Online	____
AMF Waiver	____

Name:_____D.O.B: _____Age_____

Name or Nickname for name tag: _____ **Email** _____

Address: _____ City _____ State ____ Zip _____

❑ This is a temporary college address ending (date) _____ **Phone** _____ Home or Cell

Way to contact you (circle preferred): Phone call Email (Please make sure information is listed above)

School or Employer _____ Occupation _____

Returning volunteer? Yes No If no, how did you learn about the program? _____

On Facebook? Y N How are you listed? _____

Previous Horse Experience? Yes No Experience working with individuals with special needs? Yes No
(This has no bearing on becoming a volunteer. It helps with placing you in the right position)

Please mark the box on the day(s) and time(s) you will be volunteering:

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Morning						
Evening					No evening	No evening

I am willing to be "on call": Mornings ____ Evenings ___ Jobs other than class___ Special Projects _____

Photo Release

I □ DO □ DO NOT consent to and authorize the use and reproduction by Hope on Horseback (HOHB) 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 center.

⏩Signature of volunteer _____
(Or parent/guardian if under 18 years of age) Date

Release of Claim

The instructors, riding facility owners, officers, directors and volunteers of Hope on Horseback are hereby released, acquitted and discharged from any claim for damage or suit by reason of any injury, illness or damage to person or property during the course of HOHB riding sessions, including transportation to and from the sessions, and in regard, I hereby covenant that on my own behalf not file a claim or bring suit with respect to any such injury.

⏩Signature of volunteer _____
(Or parent/guardian if under 18 years of age) Date

Emergency Medical Information and Release

In the event of an emergency, contact:

Name: _____Relation: _____ Phone: _____

Physician's Name _____ Phone _____

Preferred Medical Facility: UPMC Hamot / Allegheny St Vincent / Millcreek Community / VA Hospital

Are there any special medical needs and/or conditions that we should be aware of? Y_____N_____
If yes, please list on separate sheet of paper and submit with application.

⏩Signature of volunteer: _____ Date: _____

Please complete other side

I agree to maintain and respect the confidentiality of riders and volunteers.
⏭Signature of volunteer: _____ Date: _____

Please choose one of the following plans:

A. Consent Plan

In the event of emergency, the undersigned authorizes any licensed physician and/or emergency medical personnel to provide any medical/surgical care and/or hospitalization, for the undersigned or the dependent volunteer under the age of 18 that the undersigned represents, including anesthetic, that they determine necessary or advisable, pending receipt of specific consent from the undersigned or his/her legal representative.
In the event emergency medical aid/treatment is required due to illness or injury while participating in the HOHB program, or while being on the property, I authorize Hope on Horseback 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) listed are unable to be reached.

⏭**Consent** Signature: _____
(Volunteer or Parent/Guardian if under 18 years of age) Date

B. Non-Consent Plan

I ***do not*** give my consent for emergency medical treatment/aid in the case of illness or injury while participating in the HOHB program or while being on the property.

- » If under 18, parent or legal guardian will remain on site at all times during equine activities.
- » In the event emergency treatment/aid is required, I wish the following procedure to take place:

_____

_____

⏭**Non-Consent** Signature: _____
(Volunteer or Parent/Guardian if under 18 years of age) Date

Statement of Volunteer Responsibility

As a Hope on Horseback Volunteer, I understand that I will at all times work under the supervision and direction of a PATH certified instructor. My role is to provide a secure and safe environment during class activities including grooming, ground activities and class time as directed by the instructor. This participation may include assisting a rider to enter or exit the arena. As a volunteer I will at no time be individually responsible for the personal care, supervision, guidance or control of a minor child or developmentally disabled adult in situations unrelated to class participation.

Should assistance be needed with any physical or behavioral issue with a rider, an instructor or caregiver will be called to handle the situation.

⏭Signature of volunteer _____
(Or parent/guardian if under 18 years of age) Date