156 Sandy Hill Rd., Lexington, S.C. 29072 Phone (803) 957-7906
Email: dreamr2@mindspring.com Web page: www.dreamrider.org

Volunteer Information Form & Health History

General Information

Name: ____ Date: ________________
Address: ____
Date of Birth: ______________ Phone: (H) __________________ (W) ____________________
Email Address: ____
Employer/School: ____
Address: ____
Parent/Legal Guardian/Caregiver Name/Address/Phone Number (if under 18):
____
____
How did you learn about Dream Riders? ____
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 which area/s you are interested in:

Program
- ☐ Leading a Horse
- ☐ Side walking with a client/athlete
- ☐ Preparing Horse for lessons
- ☐ Facility Repairs
- ☐ Barn/Farm Help
- ☐ Horse Show at facility or away

Administrative
- ☐ Public Relations
- ☐ Fund Raising
- ☐ Office Help
- ☐ Corporate Campaigns
- ☐ Rider/ Volunteer Recruitment
- ☐ Photography

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 Dream Riders program.
Signature: ____ Date: ____________________
(volunteer/staff/caregiver; signed in presence of center staff)

*****Volunteer Information Form & Health History Continued ******

Photo Release

☐ I Do

☐ I Do Not

Consent to and authorize the use and reproduction by Dream Riders 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.

Date: _____________________ Signature: ____

If under 18 must be signed by Parent or guardian

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 Dream Riders, 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)

CURRENT DRIVER'S LICENSE Y N LICENSE NUMBER___________________________ STATE _________

Confidentiality Agreement

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

Signature: ____ Date: ___________________________

(volunteer/staff)

Volunteer Liability Release

Under South Carolina Law, an equine activity sponsor or equine professional is not liable for an injury to or the death of a participant in an equine activity resulting from an inherent risk of equine activity, Pursuant to Article 7, Chapter 9 of Title 47, Code of Laws of South Carolina, 1976.

As a volunteer at Dream Riders I acknowledge the risks and potential for risks of equine activities and horseback riding. I further understand that I must be careful while on the property of Dream Riders and particularly while horses are being handled. Dream Riders cannot and does not assume any liability for accidents, injury, or death to person or persons. However, I feel that the possible benefits to myself/ my son or daughter/ my ward and the clients/ athletes I work with are greater than the risk assumed. I further have reviewed and understand the content of South Carolina's Liability Law which is posted at drive entrance, barn and bathroom area. Likewise I accept full responsibility for friends and visitors accompanying myself on Dream Riders property. 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 Dream Riders, Sunrise Farms, its board of directors, instructors, volunteers, and/or employees for any and all injuries and/or losses I/ my son or daughter/ my ward may sustain while participating in activities at Dream Riders.

Date: ______________________ Signature: ____

If under 18 must be signed by Parent or guardian

<u>If volunteer is under 18 years old, parent / guardian signature required for confirmation of a minor to participate in Dream Riders' program as a volunteer</u>

I hereby approve that the above named minor may participate at Dream Riders in a volunteer position.

Date: ____________________________

Parent / Guardian Signature: ____

Print Name: ____

Volunteer Authorization for Emergency Medical Treatment Form

Name: ____ DOB: __________ Phone: _________________
Address: _____________________________________City:___________State:________Zip:________
Physician's Name: _______________________________ Preferred Medical Facility:_______________
Health Insurance Company: _______________________Policy #________________________________
Allergies to medications:____
Current medications:____
____
____

COVID-19 VACCINATED ____YES ____NO
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 DREAM RIDERS 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: ____
Volunteer, Parent or Legal Guardian if under 18

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.

O In the event emergency treatment/aid is required, I wish the following procedure to take place:
____
____
____

Date: __________________ Non-Consent Signature: ____
Volunteer, Parent or Legal Guardian if under 18