CHAPS EQUINE ASSISTED THERAPY
PMB 201 1590 Sugarland Dr. Ste. B
Sheridan, WY 82801

CHAPS Volunteer Staffing Information 2017-2018

Volunteer Name: _____ Prefer to be called: _____

Address: _____ City: _____ Zip: _____

Phone: Home: _____ Work: _____ Cell: _____

E-mail address: _____ DOB: _____

T-shirt size: _____ Hobbies/Interests: _____

_____

Horse experience is not necessary as training is required for EVERYONE; however, if you do have experience, please tell us here: _____

_____

Are you or anyone in your immediate family a veteran of the armed forces of the United States of America? Yes / No ☐ ☐

Please mark the days and hours that you are available to volunteer. We have sessions Tuesday through Saturday from 9 am to 6 pm. Sunday/Monday hours would be for equine care.

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
8:00 am							
9:00 am							
10:00 am							
11:00 am							
1:00 pm							
2:00 pm							
3:00 pm							
4:00 pm							
5:00 pm							
6:00 pm							

Interested in:

☐ Session volunteer (These volunteers help with client sessions and have direct contact with clients. This requires about a 2-hour time commitment each week)

☐ Barn help (These volunteers would be responsible for feeding, turnout and cleaning the barn. This requires about a 2-hour time commitment each week) Feeding times are 7 am M-F, 8 am weekends, 6 pm evenings.

** Volunteers who donate 6-9 hours per month become eligible for a 30-minute riding lesson once a month; Volunteers who donate 10-15 hours per month become eligible for a 50-minute riding lesson once a month; Volunteers who donate 40+ hours during the season are eligible for a trail ride at the end of the year.

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CHAPS Equine Assisted Therapy

General Liability Release

The undersigned is aware that all activities involving horses including but not limited to riding, driving, grooming, leading or events involving horses pose many inherent dangers, risks and hazards including but not limited to bodily injury and physical harm to rider, groomer, leader, handler, side walker, photographer, spectator and/or helper. I (the undersigned) freely and fully assume all such risks, dangers, and hazards and the possibility of injury, death, property damage or loss resulting from such risks, dangers and hazards.

I hereby agree as follows (please initial each line):

_____1) To assume and accept all risks, dangers and hazards in connection with my use or my minor child's or ward's use of the facilities at CHAPS or any off site activities sponsored by CHAPS

_____2) To waive any and all claims that I may have against CHAPS and the property owners as a result of my, my minor child or ward's use of the facility or participation in any off site activity sponsored by CHAPS

_____3) To release CHAPS, it's employees, board of director members, volunteers, spectators, clients, property owners and all people involved with CHAPS from any and all liability, rights of action, or causes of action arising out of contract, tort or otherwise for any loss, damage, injury or expense that I, my minor child or ward, next of kin of myself, my minor child or ward, may suffer or incur as a result of use of the facilities or participation in off-site activities sponsored by CHAPS due to any cause whatsoever

_____4) The undersigned agrees to hold harmless and indemnify CHAPS, and any employees, volunteers, board of director members, spectators, clients and or property owners from any and all liability for personal injury, property damage or death suffered by myself, my minor child or ward or by a third party as a result of use of and/or presence at the facility or off site activities sponsored by CHAPS

_____5) That, in the event of my, my minor child or ward's injury or death, this release and indemnity agreement shall be effective and binding upon mine and my minor child or ward's heirs, next of kin, executors, administrators and assigns in relation to CHAPS, it's property owners and any and all people involved.

Adult:

I acknowledge that I have read and understood this release and indemnity. I am at least 18 years of age and am aware that by signing this document, I am affecting legal rights and liabilities of myself, my heirs, next of kin, executors, administrators, and assigns in relation to CHAPS, its property owners and any and all people involved.

Name (print): _____ Date: ___/___/___

Signature: _____

Witness: _____

Minor or ward:

I acknowledge that I have read and understood this release and indemnity. I am 18 years of age or older. I have the authority as the parent or legal guardian of (please print legibly) _____ to sign and release on behalf of the minor/ward so that the minor/ward may participate and use the facilities offered by CHAPS. I am aware that by signing this document, I am affecting legal rights and liabilities of the minor/ward, his/her heirs, next of kin, executors, administrators, and assigns in relation to CHAPS, its property owners and any and all people involved.

Name (print): _____ Date ___/___/___

Signature: _____

Witness: _____

Agreement of Confidentiality:

As a participant at CHAPS, I agree to hold in strict confidence those names, all medical, social, referral, personnel and financial information regarding clients, staff, volunteers or any and all participants at CHAPS Equine Assisted Therapy at any time and in any capacity. I agree to the above stipulations regarding confidentiality, and furthermore understand that violating this agreement in any way may result in the termination of my association with CHAPS, and possible legal action.

Signature of Volunteer: _____Date:___/___/___

Signature of Parent and/or legal guardian: _____Date:___/___/___

Photo Release:

Please check one and sign:

I Do: _____

I Do NOT: _____

Consent to and authorize the use and reproduction by CHAPS Equine Assisted Therapy of any and all photographs and any other audio-visual materials taken of me/my child/my ward for promotional material, educational activities, and exhibitions or for any other use for the benefit of the program.

Signed by Client: _____Date:___/___/___

Signed by Legal Representative: _____Date:___/___/___

Volunteer Pledge:

I understand that in order to remain a volunteer at CHAPS Equine Assisted Therapy, I will be asked to follow the rules and guidelines of the organization. I have been given a copy of these rules and guidelines and will follow them.

Signed by Volunteer: _____Date: ___/___/___

Signed by Legal Representative (if under 18) _____ Date: ___/___/___

Signed by CHAPS Representative: _____ Date: ___/___/___

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Authorization for Emergency Medical Treatment

Participant's Name: _____DOB:___/___/___

Physician's Name: _____ Preferred Medical Facility: _____

Health Insurance Company: _____ Policy #: _____

Allergies to medications: _____

Current medications (including over-the-counter medications): _____

_____

Emergency Contact: _____

Relationship to Client: _____ Phone: _____

Emergency Contact: _____

Relationship to Client: _____ Phone: _____

In the event that emergency medical aid/treatment is required due to injury or illness during the process of receiving services, or while being on the property of CHAPS, I authorize CHAPS Equine Assisted Therapy staff 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 treatment

Please check and complete one of the following plans:

_____**Consent Plan:**

This authorization includes X-ray, surgery, hospitalization, medication and any treatment procedure deemed 'life saving' by the physician. This provision will be invoked only if the person(s) above is unable to be contacted.

Date: ___/___/___

Consent Signature: _____ Relation to Client: _____

Witness: _____ Date: ____/____/____

OR

_____**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 CHAPS Equine Assisted Therapy. I agree to have a parent or legal guardian remain on site at all times during equine assisted activities and therapeutic riding sessions. In the event that emergency treatment/aid is required, I wish the following procedure to take place:

_____

_____

Consent Signature: _____ Relation to client: _____

Witness: _____ Date: ___/___/___