

**HIGH HOPES THERAPEUTIC RIDING INC**  
**VOLUNTEER REGISTRATION & RELEASE FORM**

**PLEASE PRINT CLEARLY**

NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_/\_\_\_\_/\_\_\_\_ AGE \_\_\_\_\_

Check one:  Miss.  Ms.  Mrs.  Mr. HEIGHT: \_\_\_\_\_ NAME OF SPOUSE \_\_\_\_\_

ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

HOME PHONE (\_\_\_\_\_) \_\_\_\_\_ WORK PHONE (\_\_\_\_\_) \_\_\_\_\_

CELL PHONE (\_\_\_\_\_) \_\_\_\_\_ E-MAIL \_\_\_\_\_

PLACE OF EMPLOYMENT/SCHOOL \_\_\_\_\_ Occupation: \_\_\_\_\_

My employer gives time off for volunteering

My employer matches cash donations

PARENT/GUARDIAN NAME \_\_\_\_\_ PHONE \_\_\_\_\_

(for volunteers under 18 years of age)

REFERENCE NAME(non relative) \_\_\_\_\_ PHONE \_\_\_\_\_

Reason for volunteering: personal fulfillment\_\_ school requirement \_\_ court required community service \_\_ other\_\_

How did you hear of High Hopes?  Friend  Relative  Newspaper  Flyer  Other \_\_\_\_\_

**PLEASE READ EACH OF THE FOLLOWING ITEMS BEFORE SIGNING:**

Photo & Publicity Release: \_\_\_\_ I hereby consent and authorize \_\_\_\_ I do not consent to, nor do I authorize

1) High Hopes Therapeutic Riding, Inc. to use my(my child's) photograph or image in its print, online and video publications; 2) release High Hopes Therapeutic Riding, Inc., its employees and any outside third parties from all liabilities or claims that I might assert in connection with the above-described activities and 3) waive any right to inspect, approve or receive compensation for any materials or communications, including photographs, videotapes, dvds, website images or written materials, incorporating photos/images of me(my child).

**LIABILITY RELEASE:** I acknowledge the risks and potential for risks of horseback riding and working with horses, including grievous bodily harm. However, I feel that the possible benefits to myself are greater than the risks assumed. 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 High Hopes Therapeutic Riding Inc., its Board of Directors, Instructors, Therapists, Aides, Volunteers, and/or Employees for any and all injuries and/or losses I may sustain while participating as a High Hopes volunteer from whatever cause, including but not limited to the negligence of these related parties.

The undersigned acknowledges that he/she has read this Volunteer Application in its entirety; that he/she understands the terms of this release and has signed this release voluntarily and with full knowledge of the effects thereof. \_\_\_\_Initial

Date: \_\_\_\_\_ Signature \_\_\_\_\_

If volunteer is under 18 years of age, both parent & volunteer signatures are required.

**CONFIDENTIALITY POLICY**

At High Hopes, we place great importance on protecting the confidential information of our clients, our staff and our volunteers. "Confidential Information" includes, but is not limited to, personally identifiable information such as surnames, telephone numbers, addresses, e-mails, etc., as well as the non-public business records of High Hopes. In particular, medical information about clients, and information about their disabilities or special needs, must be protected as Confidential Information. Volunteers shall never disclose confidential information to anyone other than High Hopes staff. Volunteers must seek staff permission before taking any pictures or videos. **I have read and understand High Hopes Confidentiality Policy and agree to abide by same.**

Date: \_\_\_\_\_ Signature \_\_\_\_\_/\_\_\_\_\_

If volunteer is under 18 years of age, both parent & volunteer signatures are required.

**HIGH HOPES**  
**AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT FOR VOLUNTEERS**

In the event emergency medical aid/treatment is required due to illness or injury while being on the property of the agency, I authorize High Hopes to:

1. Secure and retain medical treatment and transportation, if needed.
2. Release records upon request to the authorized individual or agency involved in the medical emergency treatment.

In case of Emergency, contact: \_\_\_\_\_ Phone \_\_\_\_\_

Physician's Name: \_\_\_\_\_ Town: \_\_\_\_\_ Phone \_\_\_\_\_

Preferred Medical Facility: \_\_\_\_\_ Health Insurance Carrier: \_\_\_\_\_ Policy #: \_\_\_\_\_

Please indicate any allergies: \_\_\_\_\_

Please indicate any disability, limitations or medical conditions that may affect your volunteer role, with or with reasonable accommodations, we should be aware of \_\_\_\_\_

**CONSENT PLAN** (to be invoked in the event that your Emergency Contact cannot be reached.) I give consent for emergency medical treatment/aid (including x-ray, surgery, hospitalization, medication, and any treatment procedure deemed "life saving" by the physician) in the event of illness or injury while on the property of the agency.\*

Date: \_\_\_\_\_ Consent Signature \_\_\_\_\_

(For volunteers under 18 years of age, both parent & volunteer signatures are required)

**\* If you choose non-consent for emergency medical treatment/aid in the event of illness or injury while on the property of the agency, please request a Non-Consent Form, which requires notarization.**

**Please Complete**

Are you current CPR & First Aid Trained? \_\_\_\_\_ Drivers license # \_\_\_\_\_ State \_\_\_\_\_

Have you ever been convicted of a criminal offense \_\_\_ Yes \_\_\_ No If yes, when? \_\_\_\_\_

Please explain \_\_\_\_\_

Upon request, you may be asked to submit an application for a criminal background check. The above information may be verified, and I give permission to make inquiry of others concerning my suitability to act as a volunteer at High Hopes.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Signature of Parent/Guardian \_\_\_\_\_ / \_\_\_\_\_

(For volunteers under 18 years of age, both parent & volunteer signatures are required)

**HIGH HOPES - GENERAL INFORMATION FORM**

1. Please tell us of your experience with:

- Horses: \_\_\_\_\_
- Individuals with disabilities: \_\_\_\_\_

2. Your Volunteer Interests:

(A) **Lesson Program Volunteer.** I am interested in volunteering for the riding program in the following way(s):

- Sidewalking Riders
- Horse Leading (**must have horse experience**)
- Carriage Driving
- Equine Learning Coach (**must have horse experience**)

(B) **Equine Program Volunteer**

- Horse Care, Feeding, Cleaning Paddocks etc.

(C) **Facility/Farm Volunteer**

- General Maintenance & Repairs     Carpentry     Equipment Repair

(D) **Office Volunteer**

- Data Entry     Reception     General Office Support     Mailings

(E) **Summer - Equine Learning Day Program**

- Assists with day camp activities

(F) **Special Events & Fundraisers Volunteer**

- Serve on Special Events Planning Committees     Provide Assistance Day of an Event     Baking/cooking

(G) **Special Skills Volunteers.** Do you have skills, technical/professional experience that would be beneficial to High Hopes? If so, please check those that apply:

- Photography     Marketing     Construction     Fundraising
- Grant Writing     Computers     Graphic Design    Other? \_\_\_\_\_

2. **Please indicate your Volunteer Availability.** Please check the days and time periods you are available to volunteer. Your actual volunteer schedule will be arranged with the Volunteer Manager following your Training & Orientation session.

	Early morning 7-9am	Mornings 9-12pm	Afternoons 12:30-4:30 pm	Evenings 5pm-on	Evenings 6pm-on
<b>Mon</b>					
<b>Tue</b>					
<b>Wed</b>					
<b>Thu</b>					
<b>Fri</b>					
<b>Sat</b>					
<b>Sun</b>					

In addition to your scheduled day and time, please check if you would like to be on the Volunteer Substitute list \_\_\_\_\_

Please return completed form to:  
 Volunteer Manager  
 High Hopes Therapeutic Riding  
 36 Town Woods Road, Old Lyme, CT 06371  
 Phone: 860-434-1974 Fax: 860-434-3723