



## THERAPEUTIC RIDING VOLUNTEER APPLICATION/WAIVER

### CONFIDENTIALITY AGREEMENT:

By signing below, I confirm that I understand that all information (written or verbal) about participants at The Stables at Le Bocage 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.

### GENERAL INFORMATION:

Received: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ DOB: \_\_\_\_\_

Employer/School: \_\_\_\_\_

Address: \_\_\_\_\_

Email: \_\_\_\_\_ Parent/Legal

Guardian/Caregiver Name/Address/Phone Number: \_\_\_\_\_

How did you learn about the program? \_\_\_\_\_

Recent medical tests: \_\_\_\_\_ Last Tetanus Shot: \_\_\_\_\_ TB 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.

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Allergies: \_\_\_\_\_

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Medications: \_\_\_\_\_

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Check areas in which you are interested:

Program

Horse Handling

Sidewalking with a Student

Facility Repairs

Special Events

Horse Show

Fundraising

Administration

Public Relations

Grant Writing

Newsletter

Volunteer Recruitment

Photogrraphy/Video

PHOTO RELEASE:

By signing below, I  do/  do not consent to and authorize the use and reproduction by The Stables at Le Bocage 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.

BACKGROUND INFORMATION: Have you ever been charged with or convicted of a crime? Y N

If yes, please explain:

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By signing below, I confirm that I, \_\_\_\_\_, authorize The Stables at Le Bocage to receive information from any law enforcement agency, including police departments and sheriff 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.

CURRENT DRIVER'S LICENSE: Y N License No. \_\_\_\_\_ State \_\_\_\_\_

**WARNING:**

**Under Louisiana Law, an equine activity sponsor or equine professional is not liable for an injury to or the death of a participant in equine activities resulting from the inherent risk of equine activities pursuant to R.S. 9:2795.3.**

**NOTE: All participants, volunteers, and personnel are required to wear protective headgear while mounted. This headgear must be an ASTM-SEI approved helmet, an alternative helmet that meets the PATH guidelines for Alternative Helmet Use may be used (See, Guidelines found in the Standards manual, page \_\_\_\_).**

COVID-19/CORONAVIRUS:

Reins of Hope Therapeutic Riding Center is committed to ensuring the safety of our riders and volunteers. We are implementing certain safety guidelines at the recommendations of the Center of Disease Control (CDC), Louisiana Department of Health (LDH) and Professional Association of Therapeutic Horsemanship International (PATH). *Please initial the following.*

**\_\_\_ I understand that there is a possibility of contracting COVID-19 despite infection safety control measures taken by Reins of Hope Therapeutic Riding Center**

**\_\_\_ I will not hold Reins of Hope liable in the event that the I contract COVID-19 that can be traced back to Reins of Hope Therapeutic Riding Center**

**\*Volunteers are welcome to wear a mask, but it is not required\***

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

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

**ACKNOWLEDGMENT:**

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 therapeutic program. I have received and understand the list of volunteer requirements. I accept the responsibility of adhering to these requirements.

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

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

Witness: \_\_\_\_\_

Witness: \_\_\_\_\_

Print Name: \_\_\_\_\_

Print Name: \_\_\_\_\_