

 Date Filled Out: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Volunteer Information 2021**

 Please ID phones & e-mail, such as “work” or “mom’s cell”

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: (\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: (\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ E-mail:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

State:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ County:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Age:\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Height: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Preferred Method of Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_

**How would you like to help?** (please check all applicable areas)

\_\_\_\_\_Side walker \_\_\_\_\_Barn help \_\_\_\_\_Cleaning Facility

\_\_\_\_\_Leader \_\_\_\_\_Landscaping \_\_\_\_\_Fundraising

\_\_\_\_\_Horse Handler \_\_\_\_\_Cleaning Tack \_\_\_\_Bd. of Directors

**When are you available to help?** Our lessons normally fall between 8am and 8pm.

We request that you commit to volunteering for at least one lesson (**the same time each week for the whole session**), in order to provide consistency for our E.E. riders.

Please **list all possible time frames** in which you are available, so that we can match you with one of our clients. We will contact you to verify that your assigned time will work for you.

(For example, you might write: *Mondays: 9:00 am-1:00 pm or 4:00 pm-8:00 p.m*.)

**Mondays: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Tuesdays: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Wednesdays: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Thursdays: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Fridays: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Saturdays: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Would you do more than one lesson, back-to-back? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Is there a specific client with whom you’d like to work?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (We will do our best to keep existing rider/volunteer teams in place.)

**May we call on you as a substitute volunteer?** (You may decline when asked) \_\_Yes \_\_No

**I would like additional training in this area:** \_\_\_Leader \_\_\_Barn Help \_\_\_Horse Handler

**THANK YOU!**

Please return forms to:

Exceptional Equestrians 785 Yellow Finch Lane Washington, MO 63090

Volunteer@eemv.org (636) 390-2141

Annual Training EF Scanned

**Exceptional Equestrians of Missouri Valley, Inc.**

785 Yellow Finch Lane Washington, MO 63090-1384 636-390-2141

**VOLUNTEER RELEASE AND INDEMNIFICATION AGREEMENT**

I, the undersigned, hereby consent to assume the risk of my volunteer participation of the horsemanship program sponsored by Exceptional Equestrians of the Missouri Valley, Inc., which is located at 785 Yellow Finch Ln. I acknowledge and understand that despite reasonable safety precautions, horsemanship experiences can result in injury and even death. **Under Missouri Law an equine professional is not liable for an injury to or the death of a participant in equine activities resulting from the inherent risks of equine activities pursuant to the revised statutes of Missouri.** I do hereby forever release, acquit, discharge and hold harmless Exceptional Equestrians of the Missouri Valley, Inc., their owners, officers, directors, agents, employees, instructors, representatives and any therapists, volunteers and other persons associated with said program and the successors and assigns of each them on account of any personal injuries, physical or mental condition, known or unknown to myself and the treatment thereof, as a result of, or in any way growing out of acts of omission of said parties in connection with said activities or in any way incidental thereto.

\*Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PHOTO RELEASE**

For valuable consideration given and which is hereby acknowledged, the undersigned hereby grants to Exceptional Equestrians of the Missouri Valley, Inc. permission to take or have taken, still and moving photographs and films including television pictures of myself and I consent and authorize Exceptional Equestrians of the Missouri Valley, Inc. and the Professional Association of Therapeutic Horsemanship International and its advertising agencies, news media and any other persons interested in Exceptional Equestrians of the Missouri Valley, Inc. and its work to use and reproduce the photographs, films, and pictures to circulate and publicize the same by all means including without limiting the generality of the foregoing : newspapers, television media, brochures, pamphlets, instructional materials, books, the internet (including Facebook) and clinical material. With regard to the foregoing material, no inducements or promises have been made to me to secure my signature to this release other than the intention of Exceptional Equestrians of the Missouri Valley, Inc. to use or be used such photographs, films and pictures for the primary purpose of promoting and aiding Exceptional Equestrians of the Missouri Valley, Inc. and PATH INT’l. CONSENT \*Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*ONLY SIGN BELOW IF YOU DO NOT WANT YOUR PHOTO TAKEN\*

NON- CONSENT \*Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**EXCEPTIONAL EQUESTRIANS RELEASE AND HOLD HARMLESS AGREEMENT**

WARNING...UNDER MISSOURI LAW AN EQUINE PROFESSIONAL IS NOT LIABLE FOR AN INJURY TO OR THE DEATH OF A PARTICIPANT IN EQUINE ACTIVITIES RESULTING FROM THE INHERENT RISKS OF EQUINE ACTIVITIES PURSUANT TO THE REVISED STATUES OF MISSOURI. The undersigned assumes the unavoidable risks inherent in all horse related activities included to but not limited to bodily injury and physical harm to horse, rider, and spectator. In consideration, therefore, for the privilege of riding and /or working around horses at Exceptional Equestrians, located at 785 Yellow Finch Road, Washington, Missouri, the Undersigned does hereby agree to hold harmless and indemnify Exceptional Equestrians and further releases them from any liability or responsibility for accident, damage, injury, or illness to the Undersigned or to any horse owned by the Undersigned or to any family member or spectator accompanying the Undersigned on the premises.

 \*Signature\_\_\_\_\_\_\_\_\_\_\_\_**\_\_\_\_**

**VOLUNTEER AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT**

In the event emergency medical aid/treatment is required for myself due to illness or injury during the process of volunteering or while being on the property of the agency, I authorize Exceptional Equestrians of the Missouri Valley, Inc., staff, and/or volunteers to secure and retain medical treatment and transportation if needed and to release my records upon request to the authorized individual or agency involved in the medical emergency treatment. I also authorize my licensed physician and/or medical facility to provide any medical/surgical care for me which they determine necessary or advisable. This authorization includes x-ray, anesthesia, surgery, hospitalization, medication and any treatment procedure deemed “life and limb or organ saving” by the physician. This provision will only be invoked if a parent or guardian (if applicable) is unable to be reached. \*

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

Volunteer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone (H) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(W)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(Cell)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State\_\_\_\_\_\_\_Zip\_\_\_\_\_\_\_\_\_\_\_\_

Guardian\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone (H)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(W)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(Cell )\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone (H)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(W) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(Cell )\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State\_\_\_\_\_\_\_Zip\_\_\_\_\_\_\_\_\_

Preferred Medical Facility\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Facility Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State\_\_\_\_\_\_\_Zip\_\_\_\_\_\_\_\_\_

Health Insurance Company \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Policy #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Group #\_\_\_\_\_\_\_\_\_\_\_

**Your signature below indicates you have read and understand ALL segments of this document.**

**Volunteer signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Guardian signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\* Please sign each portion of this document to verify that you have read every section.**

**Exceptional Equestrians**

**Client Confidentiality Policy**

Participants in the Exceptional Equestrians program have the right to confidentiality of their medical conditions, progress, behavior and participation at the facility. No identifying information about clients may be released in pictures, writing or conversation by staff or volunteers without written consent of the client, parent, or guardian. Clients and Volunteers must sign a photo release for Exceptional Equestrians to use audio-visual information for promotional printed material, educational activities, exhibitions or for any other use for the benefit of the facility.

I understand that all client records at Exceptional Equestrians are confidential. I will not discuss any or part of these records with anyone other than my supervisor at Exceptional Equestrians.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature Date

[content for Covid-19 Release Form]

COVID-19 ACKNOWLEDGEMENT OF RISK AND ACCEPTANCE OF SERVICES

AS OF 15 APRIL 2020 – REQUIRED FOR ALL STAFF, CONTRACTORS, VOLUNTEERS, CLIENTS, and CLIENTS support people.

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, am aware of the risks of contracting or spreading Covid-19 while working or volunteering at Exceptional Equestrians of the Missouri Valley, Inc (EEMV), attending an event; and/or involved with direct services from EEMV during the time of a pandemic outbreak, and /or Missouri Governor’s or Franklin County’s declaration of a “stay-at-home” order(s).

I am aware that direct services and experiences increase the risk of contracting and passing on the Covid-19 or Coronavirus and agree to hold harmless EEMV and its residents, members, officers, managers, agents, employees and all other individuals I may come in contact with during this interaction and receiving of services, providing services, attending an event or volunteering within this organization.

I agree to and will follow all CDC guidelines for personal hygiene, personal safety and public safety as recommended by EEMV as well as my individual provider/practitioner. This may include, but is not limited to, waiting in my vehicle and/or home until I am asked to enter the building/farm; maintaining social distance; washing my hands prior to and following each session or activity; use of hand sanitizer frequently and upon request; wiping down surfaces with disinfecting wipes and/or wearing a protective medical mask and/or gloves. Maintaining 6-foot social distancing as much as possible is strongly recommended. **Wearing a facial mask is required when in the EE facility.**

I agree to stay home and cancel my services should I personally exhibited or have been in contact with someone who exhibited COVID-19 symptoms within the previous 14 days, including; cough, sneezing, fever, chest congestion or additional signs of potential spread of any virus or bacteria/disease. In addition, I will notify EEMV if I exhibit symptoms, test positive for COVID-19, or are in contact with some who exhibits symptoms or tested positive for COVID-19. If any of these conditions exist I will contact EEMV about potential non-direct services.

I am signing under my own free will and agree to follow these and hold harmless all individuals associated with or through my services acquired from EEMV

BY SIGNING BELOW, I CONFIRM THAT I HAVE READ AND UNDERSTAND THIS DOCUMENT.

\*In the event that the undersigned is under the age of 18, the signature of a parent or guardian is required.

SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

IF SIGNING ON BEHALF OF CLIENTS, PLEASE PROVIDE NAME(S) OF ALL THIS APPLIES FOR:

INITIAL HERE IF YOU HAVE TESTED POSITIVE FOR COVID-19 AND RECOVERED

EF Scanned