VOLUNTEER APPLICATION

ALL VOLUNTEERS MUST BE AT LEAST 14 YEARS OLD

MAGICAL MEADOWS
THERAPEUTIC HORSEBACK RIDING

FULL NAME _____ DATE OF BIRTH _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

WORK PHONE _____ CELL PHONE _____ HOME PHONE _____

EMAIL ADDRESS _____

CONTACT PREFERENCE: ☐ WORK PHONE ☐ HOME PHONE ☐ CELL PHONE ☐ EMAIL

EMPLOYER _____

EMPLOYER ADDRESS _____ CITY _____ STATE _____ ZIP _____

NAME OF SCHOOL (STUDENTS ONLY) _____

EMERGENCY CONTACT INFORMATION

EMERGENCY CONTACT NAME _____ RELATIONSHIP _____

ADDRESS _____ EMERGENCY CONTACT PHONE _____

PHYSICIAN NAME _____ PHYSICIAN PHONE _____

HOSPITAL NAME _____ HOSPITAL CITY _____

☐ In case of an emergency, I give permission to MAGICAL Meadows to secure medical treatment including x-ray, surgery, hospitalization and medication.

☐ I do not give Permission for medical treatment.

SIGNATURE _____ DATE _____

PLEASE EMAIL COMPLETED FORM TO THEMAGICALMEADOWS@YAHOO.COM

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PHOTO & MEDIA RELEASE

☐ I consent to and authorize the use and reproduction by MAGICAL Meadows Riding Center of any and all photographs & any audio-visual materials of me for promotional material, educational activities, publications, broadcast, website or for any use for the benefit of the program.

☐ I do not give Permission To use my photograph.

SIGNATURE _____ DATE _____

STATEMENT OF CONFIDENTIALITY

The inherent right of all individuals is to be respected as equal. In all our programs, we are committed to maintain the highest ethical standard in respect to personal information. Therefore, the MAGICAL Meadows, Inc. has established this Statement of Confidentiality.

I, the undersigned, agree to hold in confidence all information given to me regarding any specific individual here at MAGICAL Meadows. All health histories and personal information regarding particular individuals is covered by this agreement.

I will not discuss with my family, friends, acquaintances, or general public, specific individuals, riders, staff or volunteers, or any information relating to an individual here at MAGICAL Meadows.

SIGNATURE _____ DATE _____

VOLUNTEER TERMINATION POLICY

Volunteering at MAGICAL Meadows is a privilege. We do appreciate all the skill, energy and commitment volunteers bring to our programs. Sometimes it may be necessary to remove a volunteer from a specific class or from programs of MAGICAL Meadows.

Please understand, for the safety, security and continuation of excellence in programs, an inattentive volunteer, or one who cannot perform the functions or duties of a volunteer, will be removed from classes, and may be placed at other aspects of the program, or invited NOT to return to MAGICAL Meadows.

Absolutely no intoxicated or chemically impaired volunteer will be allowed to work/volunteer at MAGICAL Meadows. If there may be a question, MAGICAL Meadows staff will ere on the side of caution, and will not permit the individual to volunteer.

SIGNATURE _____ DATE _____

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VOLUNTEER LIABILITY RELEASE

As a volunteer at the MAGICAL Meadows Riding Center, I acknowledge the risks and potential risks of a horseback riding program. However, I feel that the possible benefits to myself and the special riders that I work with are greater than the risk assumed. I hereby, intending to be legally bound, for myself and my heirs and assigns, executors or administrators, waive and release forever all claims for damages against The MAGICAL Meadows, Inc., its advisory council, instructors, therapists, volunteers, riders, and/or employers for any and all injuries and/or losses I may sustain while participating at the MAGICAL Meadows Riding Center.

SIGNATURE _____ DATE _____

PARENT/GUARDIAN NAME/SIGNATURE (IF UNDER 18) _____ DATE _____

BACKGROUND CHECK RELEASE

LEGAL NAME OF VOLUNTEER _____ DATE OF BIRTH _____

SOCIAL SECURITY NUMBER _____

I hereby authorize the MAGICAL Meadows Inc. to conduct a limited criminal history check on me through the Indiana Criminal Justice Institute on-line database. I understand that this confidential information will be kept in the locked files at the MAGICAL Meadows. In addition, I may request a copy of this report that is produced through this check.

SIGNATURE _____ DATE _____

PARENT/GUARDIAN NAME/SIGNATURE (IF UNDER 18) _____ DATE _____

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ADDITIONAL INFORMATION

PLEASE DESCRIBE ANY MEDICAL LIMITATIONS RELATING TO YOUR ABILITY TO COMPLETE YOUR VOLUNTEER DUTIES.

DESCRIBE ANY EXPERIENCE YOU HAVE HAD WORKING WITH HORSES.

DESCRIBE ANY EXPERIENCE YOU HAVE HAD WORKING WITH PEOPLE WHO HAVE SPECIAL-NEEDS.

HOW DID YOU HEAR ABOUT MAGICAL MEADOWS?

ADDITIONAL COMMENTS OR QUESTIONS.

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