

LifeStriders

Therapeutic Riding Center

W288S290 Elmhurst Dr., Waukesha, WI 53188, (262)-565-6124

Email:
striders@lifestriders.org

Website:
www.lifestriders.org

VOLUNTEER FORM

Last Name: _____ First Name _____ DOB _____

Address: _____

City: _____ State _____ Zip _____ Phone _____

Email _____

If Student: Age _____ Name of school _____

Employer _____

Address: _____

Email _____

City: _____ State _____ Zip _____ Phone _____

Parent Guardian Name and Address (If Applicable)

* _____ Phone _____

* _____ Phone _____

CPR Certified Yes _____ No _____ Date of Certification _____

Please Check Areas You Are Interested In:

Program Volunteer

Special Events

Administration

___ Class Volunteer

___ Open House

___ General Office

___ Stable Management

___ Fundraising

___ Volunteer Recruit

___ Grounds Keeping

___ Volunteer Training

___ Grant Writing

___ Photography

___ Advertising

Photo Release

I consent to authorize the use and reproduction by LifeStriders Inc. 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.

Date ___/___/___

Signature _____

Volunteer Liability Release

As a volunteer at LifeStriders I acknowledge the risk of a horseback-riding program. However, I feel that the possible benefits to myself and the clients I work with, are greater than the risk I assume. I hereby, intending to be legally bound, for myself, my heirs and assigns, executors or administrators waive, and release forever all claims for damage against LifeStriders Inc., its Board of Directors, instructors, therapists, volunteers, and or employees for any and all injuries and or losses I may sustain, while participating in LifeStriders program.

Date: ___/___/___

Signature: _____

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VOLUNTEER AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

In the event emergency medical aid/treatment is required due to illness or injury during the process of volunteering, or while being on the property of the agency, I authorize a representative of LifeStriders to secure and retain medical treatment and transportation if needed.

Volunteer's Name _____ Phone: _____

Address _____

City _____ State _____ Zip _____

In the event of an emergency, Please notify:

Name _____ Phone: _____
Name _____ Phone: _____

Physician's Name _____

Phone: _____

Preferred Medical Facility _____

Health Insurance Company _____ Policy Number _____

Consent Plan

This Authorization includes x-rays, surgery, hospitalization, and medication and any treatment deemed "life saving" by the physician. This provision will only be invoked if the person above is unable to be reached.

Print Name: _____

Date _____ Consent Signature _____

(Volunteer Parent or Guardian)

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 volunteering or while on the property of the agency. In the event that emergency treatment/aid is required, I wish the following procedure to take place:

Date _____ Non-Consent Signature _____

(Volunteer Parent or Guardian)

Print Name: _____