Volunteer Paperwork 2017

Name: ___________________________________________  Age: __________________

E-mail: ___________________________________________  Phone: ____________________

How did you hear about NDSU EAAT?

☐ E-mail  ☐ Radio
☐ NDSU Equine Science website  ☐ Word of mouth
☐ Class (which class and campus, NDSU, MSUM, etc.)  ☐ Other (please describe)

________________________________________  ______________________________________

Please check areas you are interested in helping out with:

☐ Sidewalking with riders  ☐ Barn work*  ☐ Fundraising
☐ Photography/videography  ☐ Grooming and tacking horses*  ☐ Grant writing
☐ Newsletter  ☐ Horse handling*  ☐ Marketing

*Additional training is required to work directly with horses

The summer session runs May 8 – June 29. Please check days and times you are available to volunteer as a sidewalker:

☐ Mondays 3-4 p.m.  ☐ Wednesdays 3-4 p.m.  ☐ Thursdays 3-4 p.m.
☐ Mondays 4-5 p.m.  ☐ Wednesdays 4-5 p.m.  ☐ Thursdays 4-5 p.m.
☐ Mondays 5-6 p.m.  ☐ Wednesdays 5-6 p.m.  ☐ Thursdays 5-6 p.m.

Volunteer attendance is critical for participants to be able to ride! If a volunteer is absent without letting us know, an individual may not be able to ride that day. Please give us a minimum of 24 hours notice so we can find a replacement. If you know of any days or times you are unavailable between May 8 and June 29, please write those below.

________________________________________  ______________________________________
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CONFIDENTIALITY POLICY:

NDSU EAAT has strict confidentiality guidelines regarding the right to privacy for all individuals involved with the program. This policy extends not only to program participants and their diagnosis/special needs and any sensitive information, but also extends to protect the privacy of others involved with the program including volunteers and staff. It is extremely important that volunteers and staff respect the individual circumstances of those involved with the program. Please do not take the issues of our participants or personal information regarding other individuals beyond the facility. Breach of this confidentiality policy may result in reprimand, loss of certain job/volunteer responsibilities, or termination of services/employment.

Date: ___________________ Signature: ________________________________________________
   Participant

Date: ___________________ Signature: ________________________________________________
   Parent or Legal Guardian if under 18 years old

PHOTO RELEASE:

☐ I DO consent to and authorize the use and reproduction by NDSU of any and all photographs and any other audio/visual materials taken of me or my minor child or dependent for promotional material, educational activities, exhibitions or for any other use for the benefit of the NDSU equine assisted activities and therapies program.

☐ I DO NOT consent to and authorize the use and reproduction by NDSU of any and all photographs and any other audio/visual materials taken of me or my minor child or dependent for promotional material, educational activities, exhibitions or for any other use for the benefit of the NDSU equine assisted activities and therapies program.

Date: ___________________ Signature: ________________________________________________
   Participant

Date: ___________________ Signature: ________________________________________________
   Parent of Legal Guardian if under 18 years old
Authorization for Emergency Medical Treatment Form 2017

□ Volunteer    □ Staff

Name: _______________________________   DOB: ________ Phone: __________________

Address: _______________________________   City: ___________ State: _______ Zip: ________

Physician’s Name: ____________________   Preferred Medical Facility: __________________________

Health Insurance Company: ____________________   Policy #: __________________

Brief health history. Please describe your current health status, particularly regarding the physical/emotional demands of working in an equine-assisted activities program including fitness, cardiac, respiratory, bone or joint function, recent hospitalizations/surgeries or lifestyle changes:

______________________________________________________________________________

______________________________________________________________________________

List any allergies (medication, food, bees, etc.):

______________________________________________________________________________

Current medications:

______________________________________________________________________________

In the event of an emergency, contact:

Name: _______________________________ Phone: __________________ Relationship: ____________

Name: _______________________________ Phone: __________________ Relationship: ____________

In the event emergency medical aid/treatment is required due to illness or injury during the process of receiving services, or while being on the property of the agency, I authorize North Dakota State University to:

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

PLEASE CHOOSE ONE

□ Consent Plan
This authorization includes x-ray, surgery, hospitalization, medication and any treatment procedure deemed life-saving by the physician. This provision will only be invoked if the person(s) above is unable to be reached.

□ 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 receiving services or while being on the property of the agency.

In the event emergency treatment/aid is required, I wish the following procedures to take place:

Date: _______________________ Signature: ____________________________________________

Participant or Parent or Legal Guardian if under 18 years old

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