VOLUNTEER INFORMATION / REGISTRATION

Name ____ Date _________________________________

Phone (h) _____________________________ cell _________________________ (w)____________________________

Address ____
Street Town State & zip
e-mail ____ Date of birth _____________________

(if under 18) Parent/legal guardian name ____

Address (if different) ____

Phone (h) ____________________________ cell __________________________ (w)___________________________
(if different)

HEALTH HISTORY

Please describe your current health status. Take into account the physical demands of working in a therapeutic riding program, requiring up to 45 minutes of walking and jogging with a rider. Address fitness, cardiac condition, bone or joint function, any recent surgeries or health problems. NOTE: If unable to jog, you can still work in lessons – we just need to know!
Allergies: ____

Other: ____

____

Date last Tetanus shot _________________________________ NOTE: important to be current, within last 8 to 10 years

STATEMENT of UNDERSTANDING
The information provided is accurate to the best of my knowledge. I know of no reason why I should not participate in Sky Therapeutic Therapeutic Riding LI's lesson program.

Signature: ____ Date _______________________________
Volunteer

LIABILITY RELEASE
I hereby certify that, being aware of the risks and exposures to personal injury involved through equestrian activities, I hereby release Sky Therapeutic Riding and its employees assisting in any official capacity on their behalf, from all and every claim for damages which may occur to me or my property in any connection with any lesson, clinic, practice, schooling or any work with horses on the barn grounds or away from the grounds.

Signature ____ Date________________________________
Volunteer **or if under 18**, Parent/Legal Guardian

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PROMOTIONAL PHOTOGRAPHY RELEASE

I ❑ DO

❑ DO NOT

consent to and authorize the use and reproduction of any and all photographs and any other audio/visual materials taken of me by Sky Riding LI for promotional material, educational activities, exhibitions or for any other use for the benefit of the program.

Signature: ____ Date: _______________________

CONFIDENTIALITY AGREEMENT

I understand that all information (written and verbal) about participants at Sky Therapeutic Riding is confidential and will not be shared with anyone without the express written consent of the participant or his/her parent/legal guardian.

Signature ____ Date ___________________________

Your Volunteer AVAILABILITY-

Sunday ONLY ______________a.m. ______________p.m.

Mail forms to: Sky Riding LI, 2415 Henry St, Merrick NY 11566 or email nancy.tejo@skyridingli.com