SONRISAS TRAILS THERAPEUTIC RIDING
PO BOX 1093 * SAN ANGELO, TX * 76902
(325) 949-4837

NAME:_____EMAIL:_____CELL:_____

VOLUNTEER OF: COMMUNITY-AT-LARGE:_____ ASU:_____
SCHOOL:_____ GAFB:_____

HOME ADDRESS:_____

CITY:_____STATE:_____ZIP:_____

WORK ADDRESS/NAME_____ WORK PHONE:_____

CITY:_____STATE:_____ZIP:_____

NAME OF SCHOOL (if student)/EMPLOYER_____

DATE OF BIRTH:_____ DRIVERS LICENSE #:_____STATE:_____

MILITARY SERVICE DATES:_____BRANCH:_____

DATE/TYPE OF DISCHARGE:_____

HIGH SCHOOL GRAD?_____GED?_____COLLEGE MAJOR?_____

DEGREE (S)?_____ SPECIAL TRAINING/CERTIFICATIONS:_____

HOW DID YOU LEARN ABOUT SONRISAS? _____

BI-LINGUAL?_____WHAT LANGUAGE(S)?_____

PREVIOUS VOLUNTEER OR HORSE EXPERIENCE: _____

CURRENT VOLUNTEER ACTIVITIES?_____

PERSONAL REFERENCES (one reference other than spouse or immediate relatives):

NAME:_____ PHONE #_____

HAVE YOU EVER BEEN CONVICTED OF A FELONY OR A FIRST DEGREE MISDEMEANOR? IF SO, WHAT CHARGE?_____

As a volunteer of the Sonrisas Trails Therapeutic Riding Program, I understand that all client information is confidential. I understand and agree not to discuss or make written reports without prior approval from the CEO or Program Director. I also agree that at no time will I use the last name of any client. I also acknowledge that any information provided in this form may be used for a background check should a situation arise which should require such a check.

I, _____ (volunteer/staff), authorize **Sonrisas Trails Therapeutic Riding** to receive information from any law enforcement agency, including police department and sheriff's departments, of this state or any other state or federal government, to the extent permitted by state and federal law, pertaining to any convictions I may have had for violations of state or federal criminal laws, including but not limited to convictions for crimes committed upon children or animals.

I understand that such access is for the purpose considering my application as an employee/volunteer, and that I expressively DO NOT authorize Sonrisas Trails Therapeutic Riding, its directors, officers, employees, or other volunteers to disseminate this information in any way to any other individual, group, agency, organization, or corporation.

Signature: _____ Date: _____

Authorization for Emergency Medical Treatment Form

☐ **Participant** ☐ **Staff** ☐ **Volunteer**

Name: _____ DOB: _____ Phone: _____

Address: _____

Physician's Name: _____ Preferred Medical Facility: _____

Health Insurance Company: _____ Policy #:_____

Allergies to Medications: _____

Current Medications: _____

RECENT MEDICAL TESTS: Last Tetanus Shot: _____ Tuberculosis Test: + - Date:_____

In the event of an emergency, contact:

Name: _____Relation: _____ Phone: _____

Name: _____ Relation: _____ Phone: _____

Consent Plan

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 **SONRISAS TRAILS THERAPEUTIC RIDING** 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.

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 below is unable to be reached.

Date:_____ Consent Signature:_____

Client, Parent or Guardian or Volunteer

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.

☐Parent or legal guardian will remain on site at all times during equine assisted activities

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

_____

_____

_____

Date:_____ Non-Consent Signature:_____

Client, Parent or Guardian or Volunteer

STATE OF TEXAS
COUNTY OF TOM GREEN

RELEASE OF ALL CLAIMS

I, _____, individually or on behalf of _____(for Minors only) for and in consideration of the opportunity for _____ to participate in the Sonrisas Trails Therapeutic Riding, INC program, to use the Sonrisas Trails Therapeutic Riding, INC facilities and/or to ride Sonrisas Trails Therapeutic Riding, INC horses do hereby Release, Acquit and Forever Release Sonrisas Trails Therapeutic Riding, INC and any board of directors, advisory board, therapists, aides, volunteers, employees, agents or servants as set forth below:

I

I fully understand and acknowledge that working with and riding a horse involves inherent risks and dangers of accident, injury and even death. I am personally acquainted with all of the elements of any activity in which I/my child(ren) will be engaging in and voluntarily assume the risk of injury or death with regard to those activities and based upon my own analysis have made the decision to participate, individually, or thorough my children or other relatives.

II

I understand and agree that I fully and freely accept all responsibility for any injury which may occur to me or _____ and release Sonrisas Trails Therapeutic Riding, INC and any of their board of directors, instructors, therapists, aides, volunteers, employees, agents or servants from any and all liability and damages and they cannot be held responsible an any manner for any injury of any nature to me/my child(ren).

III

I hereby release, acquit and forever discharge Sonrisas Trails Therapeutic Riding, INC and any of their board of directors, advisory board, instructors, therapists, aides, volunteers, employees, agents or servants form any and all liability for injury or death caused to me/my child(ren) or my property, wherever situated and of whatever nature, whether resulting from their negligence or otherwise which has not yet occurred or for any reason whatsoever.

IV

I further agree to defend, indemnify, and hold harmless Sonrisas Trails Therapeutic Riding, INC and any of it's board of directors, instructors, therapists, aides, volunteers, employees, agents or servants from any and all claims, demand obligations, actions, causes of actions, damages, costs, attorney fees and expenses incurred which may hereafter be asserted by any person, entity, trustee, firm or corporation whomsoever claiming by, through, or under the undersigned.

V

This RELEASE is intended to cover any potentially negligent, or any other, conduct which may arise on the part of Sonrisas Trails Therapeutic Riding, INC and any of their board of directors, instructors, therapists, aides, volunteers, employees, agents or servants, including but not limited to premises liability which may arise as a result of the maintenance of any unreasonably dangerous premise.

I acknowledge that I have read and understand this agreement, the intended effect of which is to RELEASE FROM LIABILITY Sonrisas Trails Therapeutic Riding, INC and any of their board of directors, advisory board, instructors, therapists, aides, volunteers, employee's agents or servants and that this agreement shall be binding upon me, my heirs, executors, administrators or assigns.

WARNING

UNDER TEXAS LAW (CHAPTER 87, CIVIL PRACTIVE AND REMEDIES CODE) AND 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.

Signed this the _____day of _____.20___

Signature of Volunteer Parent/Guardian on behalf of Minor_____

Minor_____

Name of Child(ren) _____

SONRISAS TRAILS THERAPEUTIC RIDING,INC.

_____Participant _____Staff ____Volunteer

PHOTO RELEASE

I ____do/____do not consent to and authorize the use and reproduction by Sonrisas Trails Therapeutic Riding, of any and all photographs and any other audiovisual materials taken of me/my son/my daughter/my ward for promotional printed material, educational activities or any other use for the benefit of the program.

Date: _____ Signature: _____

CONSENT PLAN

In the event an 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 SONRISAS TRAILS THERAPEUTIC RIDING 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. 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 is unable to be reached.**

Date**:**_____ Signature:_____

In Case of Emergency, Contact:

Name: _____Relation: _____ Phone: _____

Name: _____Relation: _____ Phone: _____

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 in the property of the agency.

___Yes/ ___No Parent or legal guardian will remain on site at all times during equine assisted activities.

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

_____

_____

Date: _____ Non -Consent Signature: _____

ALL AREAS OF FORM MUST BE COMPLETED

Additional Medical Information

Name: _____

Do you have any of the following or any other medical conditions?

** Heart Condition _____ Yes _____ No

Asthma/Breathing Problems _____ Yes _____ No

History of Seizures _____ Yes _____ No

Temperature Intolerance to Heat or Cold _____ Yes _____ No

** Diabetes _____ Yes _____ No

Do you have any sight or hearing impairments? _____ Yes _____ No

Severe Allergic Reaction _____ Yes _____ No

If yes, please explain:

_____

_____

_____

Are you pregnant? _____ Yes _____ No

** If severe, a physician's clearance may be required. (Ask staff)