



GAIT TRC
PO Box 69
Milford, PA 18337
570-409-1140 (Tel)
570-409-1078 (Fax)
gaitpa@gmail.com (Email)
www.gaitpa.org (Website)



Call (570) 409-1140 and ask for the *Volunteer Coordinator/Program Assistant* if you have any questions regarding this packet.

FORMS

Enclosed are four (4) forms that need your attention and signature:

- Form 1 Volunteer/Staff Contact Information and Health History Form
- Form 2 Volunteer/Staff Authorization for Emergency Medical Treatment Form
- Form 3 GAIT TRC Confidentiality Policy
- Form 4 GAIT TRC General Releases Form

All Forms must be *completed and signed* before turning it in. These forms are valid for the current year only. *Please print clearly!*

If you are under the age of 18, a parent or guardian must sign all highlighted areas!

Please be sure to read and then *understand the Confidentiality Policy*. Your signature on this confidentiality policy means you understand and will observe this policy! If you have any questions what-so-ever, please ask the Executive Director! This is the most important form at GAIT TRC!

ATTIRE

All participants should come dressed appropriately for doing farm chores and/or working with the horses. No open toed shoes are allowed

- Boots or sneakers – be prepared to walk in mud!
- Long pants – but not so long that you step on them! (No shorts!)
- No scarves!
- No ponchos!
- No noisy clothing (ex: swishy pants)!
- No jewelry anywhere on the body!

GAIT Therapeutic Riding Center (GAIT TRC) is a Federal 501(c)(3) non-profit, charitable organization (EIN 22-3444872) for the benefit of special needs persons in Pennsylvania, New York, and New Jersey.



Volunteer/Staff Contact Information and Health History Form

(Form 1)
Volunteer _____ Staff _____



I. CONTACT INFORMATION:

Volunteer/Staff Full Name: _____
 Current Mailing Address: _____ City _____ ST _____ ZIP _____
 Employer/School: _____
 Phone: (H) _____ Date of Birth: _____ (Cell) _____
 (Work) _____ E-mail address: _____

Please indicate if you are: A New Volunteer? _____ A Returning Volunteer? _____
 What year did you start volunteering at GAIT TRC? _____
 If you are a new volunteer, you are an automatic LEVEL 1 status (Side-Aide Level).
 If you are a returning volunteer, what is your current level of training that you earned at GAIT? _____
 (Level 1= Side-Aide, Level 2=Groomer, Level 3=Leader, Level 4= Mounter)

PARENT/LEGAL GUARDIAN NAME AND ADDRESS (IF UNDER 18):

Name: _____
 Address: _____
 How did you learn about GAIT THERAPEUTIC RIDING CENTER's program? _____

II. HEALTH HISTORY

Please describe your current health status, particularly regarding the physical/emotional demands of working a therapeutic riding program. Address fitness, cardiac, respiratory, bone or joint function, recent hospitalization/surgeries or other lifestyle changes: _____

RECENT MEDICAL TESTS:

Tetanus Shot: _____ Tuberculosis Test + - Date: _____
 (Consult you physician or local health department if you are not up to date with these shots/tests)
 Allergies: _____
 Medications: _____

PLEASE CHECK AREAS YOU WOULD BE INTERESTED IN:

- | | | | |
|---|---|--|---|
| <u>Program</u> | <u>Special Events</u> | <u>Administration</u> | |
| <input type="checkbox"/> Horse Handling | <input type="checkbox"/> Horse Show | <input type="checkbox"/> Public relations | <input type="checkbox"/> Budget & finance |
| <input type="checkbox"/> Sidewalking with a Student | <input type="checkbox"/> Fundraising | <input type="checkbox"/> Newsletter | <input type="checkbox"/> Future planning |
| <input type="checkbox"/> Stable management | <input type="checkbox"/> Ride-A-Thon | <input type="checkbox"/> Volunteer Recruitment | |
| <input type="checkbox"/> Facility repairs | <input type="checkbox"/> Special Olympics | <input type="checkbox"/> Photography/video | |
| <input type="checkbox"/> Activities Program | | | |

I understand that the information provided above is accurate to the best of my knowledge. I know of no reason why I should not participate in GAIT THERAPEUTIC RIDING CENTER's programs.

Signature: _____ **Date:** _____

(Volunteer/staff, signed in presence of G.A.I.T. staff member)



Authorization for Emergency Medical Treatment Form

(Form 2)



Volunteer _____ Staff _____

Name: _____ DOB: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Physician's Name: _____ Preferred Medical Facility: _____

Health Insurance Company: _____ Policy: _____

Allergies to medications: _____

Current medications: _____

IN THE EVENT OF AN EMERGENCY, CONTACT:

Name: _____ Relation: _____ Phone: _____

Name: _____ Relation: _____ Phone: _____

Name: _____ Relation: _____ Phone: _____

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 GAIT TRC, I authorize GAIT TRC 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.

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.

Consent Signature: _____

Date: _____

(Client, parent or legal 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 receiving services or while being on the property of GAIT TRC:

- Parent or legal guardian must remain on site at all times during equine assisted activities.
- In the event emergency treatment/aid is required, I wish the following procedure to take place:

Non-Consent Signature: _____

Date: _____

(Client, parent or legal guardian)



GAIT THERAPEUTIC RIDING
CENTER'S
CONFIDENTIALITY POLICY
(Form 3)



Volunteer _____ Staff _____

- I. GAIT TRC shall preserve the right of confidentiality of all individuals in its programs. Riders and their families have a right to privacy that gives them control over the dissemination of their medical or other sensitive information.
- II. The staff of GAIT TRC shall keep confidential all medical, social, referral, personal and financial information regarding a person and his/her family.
- III. Anyone who works, volunteers or provides services to GAIT TRC shall be bound by this policy. This includes but is not limited to:
- Full and part-time staff
 - Independent contractors
 - Temporary employees
 - Volunteers
 - Board Members
- IV. As a general rule, infants and children under the age of 18 **DO NOT** have the legal authority to consent to disclosure of medical or sensitive information. Only parents, legal representatives or others defined by state statute generally has this authority.
- V. Penalties that can result from breaching confidentiality may include reprimand, loss of certain job responsibilities and termination.

STATEMENT OF CONFIDENTIALITY

I understand and will observe the confidentiality policy of GAIT THERAPEUTIC RIDING CENTER

(Signature)

(Date)

(Witnessed by Staff Member)

(Date)



GAIT THERAPEUTIC RIDING CENTER'S General Releases Form (Form 4)



Volunteer _____ Staff _____

RELEASES:

There are 5 separate releases on this form. Each release must be signed separately. Hence, there should be 5 signatures on this page.

1. LIABILITY RELEASE:

_____ (client's name) would like to participate in GAIT TRC's program. I acknowledge the risks and potential for risks of horseback riding. However, I feel that the possible benefits to my self/my son/my daughter/my ward are greater than the risk assumed. I hereby, intending to be legal bound, for myself, my heirs and assigns, executors or administrators, waive and release forever all claims for damages against GAIT TRC, its Board of Directors, Instructors, Therapists, Aides, Volunteers and/or Staff for any and all injuries and/or losses I/my son/my daughter/my ward may sustain while participating in any GAIT TRC programs.

Signature: _____ Date: _____

2. PHOTO RELEASE (for all printed materials):

- DO
 DO NOT

Consent to and authorize the use and reproduction by GAIT TRC of any and all photographs and any other audio/visual materials taken of me/my son/my daughter/my ward for promotional printed material, education activities or for any other use for the benefit of the program.

Signature: _____ Date: _____

3. GAIT THERAPEUTIC RIDING CENTER'S WEBSITE RELEASE:

- DO
 DO NOT

Consent to and authorize the use and reproduction by GAIT TRC of any and all photographs and any other audio/visual materials taken of me/my son/my daughter/my ward for promotional web site material, education activities or for any other use for the benefit of the program.

Signature: _____ Date: _____

4. AUTHORIZATION FOR GAIT TRC TO DO A BACKGROUND CHECK:

I, _____ (volunteer/staff), authorize GAIT TRC to receive information from any law enforcement agency, including police departments 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 feral criminal laws including but not limited to convictions for crimes committed upon children or animals.

I understand that such access is for the purpose of considering my application as an employee/volunteer, and that I expressly DO NOT authorize the NARHA center, 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: _____

Current Drivers License: Y N License Number: _____ State: _____

5. CONFIDENTIALITY AGREEMENT:

I understand that all information (written and verbal) about participants at this PATH Accredited Center is confidential and will not be shared with anyone without the expressed written consent of the participant and their parent/guardian in the case of minor.

Signature: _____ Date: _____