



Call Connie McComb, Volunteer Coordinator, at (570) 409-1140 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 G.A.I.T. Inc. Confidentiality Policy
- Form 4 G.A.I.T. Inc. General Releases Form

All Forms must be *completed and signed* before turning it in. These forms are valid for one year. *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 me. This is the most important form at G.A.I.T.!

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 jewelry anywhere on the body! (Our horses like to nibble on them!)

G.A.I.T. 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 Name: _____ Date of Birth: _____
 Address: _____
 Employer/School: _____
 Work Address: _____
 E-mail address: _____
 Phone: (H) _____ (W) _____ (C) _____

PARENT/LEGAL GUARDIAN NAME AND ADDRESS:

Name: _____
 Address: _____
 How did you learn about G.A.I.T.'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 your 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 G.A.I.T.'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 G.A.I.T., I authorize G.A.I.T. 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 G.A.I.T.

- 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)

G.A.I.T. Inc.
"Genuine Alternative In Therapy"
CONFIDENTIALITY POLICY
(Form 3)

Volunteer_____ Staff_____

- I. G.A.I.T. 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 G.A.I.T. 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 G.A.I.T. 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 G.A.I.T.

(Signature)

(Date)

(Witnessed by Staff Member)

(Date)



G.A.I.T. Inc. 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 G.A.IT.'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 G.A.I.T., 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 G.A.I.T. programs.

Signature: _____ Date: _____

2. PHOTO RELEASE (for all printed materials):

- DO
- DO NOT

Consent to and authorize the use and reproduction by G.A.I.T. 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. G.A.I.T.'S WEBSITE RELEASE:

- DO
- DO NOT

Consent to and authorize the use and reproduction by G.A.I.T. 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 G.A.I.T. TO DO A BACKGROUND CHECK:

I, _____ (volunteer/staff), authorize G.A.I.T. 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 NARHA 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: _____