

Sierra Therapeutic Equestrian Program, Inc.

1680 Sandra Lane • Minden • Nevada • 89423



Volunteer/Staff Information Form and Health History

General information

Name: _____ Date: _____

Address: _____

Date of Birth: _____ Phone: (H) _____ (W / C) _____

Employer/School: _____

Address: _____

Parent/Legal Guardian/Caregiver Name/Address/Phone Number: _____

How did you learn about the program? _____

Recent medical tests: Last Tetanus Shot: _____

Health History

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

Allergies: _____

Medications: _____

Check which areas you are interested in:

Program

- Horse Handling
- Sidewalking with a Student
- Stable Management
- Facility Repairs

Special Events

- Horse Show
- Fundraising
- Special Olympics
- Trail Rides

Administration

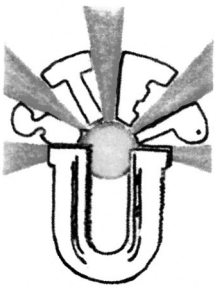
- Public Relations
- Grant Writing
- Newsletter
- Volunteer Recruitment

- Photography/Video
- Budget & Finance
- Future Planning

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 this center's program.

Signature: _____ Date: _____

(volunteer/staff/caregiver; signed in presence of STEP staff)



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Volunteer/Staff Information Form and Health History - Page 2

Name: _____

Photo Release

- I DO
 DO NOT

Email: _____

consent to and authorize the use and reproduction by Sierra Therapeutic Equestrian Program, Inc.
of any and all photographs and any other audio/visual materials taken of me for promotional material, educational activities, exhibitions
or for any other use for the benefit of the center

Signature: _____ Date: _____

Background Information

Have you ever been charged with or convicted of a crime? Y N; please explain _____

I, _____ (volunteer/staff), authorize Sierra Therapeutic Equestrian Program 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 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 of considering my application as an employee/volunteer, and that I expressly DO NOT
authorize STEP/PATH, its directors, officers, employees or other volunteers to disseminate this information in any way to any other
individual, group, agency, organization or corporation.

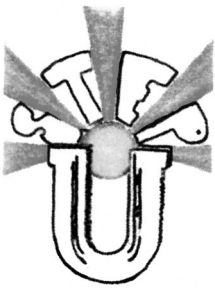
Signature: _____ Date: _____
(volunteer/staff)

CURRENT DRIVER'S LICENSE Y N LICENSE NUMBER _____ STATE _____

Confidentiality Agreement

I understand that all information (written and verbal) about participants at this PATH 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 a minor

Signature: _____ Date: _____
(volunteer/staff)



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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: _____

In the event of an emergency, contact:

Name: _____ Relation: _____ Phone: _____

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 Sierra Therapeutic Equestrian Program 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(s) above is unable to be reached.

Date: _____ Consent Signature: _____

Client, Parent or Legal Guardian
Signed in the presence of STEP staff

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 procedure to take place:

Date: _____ Non-Consent Signature: _____

Client, Parent or Legal Guardian
Signed in the presence of STEP staff