



DREAM A DREAM THERAPEUTIC HORSEMANSHIP  
23650 Round Mountain Circle ♦ Leander, TX 78641  
(512) 260-5957 ♦ info@dadth.org

## WELCOME TO D.A.D.T.H. and THANK YOU!

### VOLUNTEER INFORMATION FORM

#### I. PERSONAL INFORMATION

Date: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Email Address: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

#### II. AVAILABILITY

Would you like to be on the substitute list?  YES  NO

(If a volunteer calls in ill or has an exam, etc., we call volunteers on the substitute list and ask if they are available.)

DAYS AND TIMES TYPICALLY AVAILABLE:

\_\_\_\_\_

#### III. GENERAL INFORMATION

How did you find out about DADTH? (Please list friends name if appropriate.)

\_\_\_\_\_

Do you have any special skills you would like to offer to DADTH such as photography, computer skills, etc.?

\_\_\_\_\_

If you are volunteering as a requirement for a class, etc., please complete the following:

Instructor: \_\_\_\_\_ Course/Program: \_\_\_\_\_

School: \_\_\_\_\_ Hours Needed: \_\_\_\_\_



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## D.A.D.T.H . VOLUNTEER SIGNATURE SHEET

TEXAS LAW EFFECTIVE SEPTEMBER 1, 1995

UNDER TEXAS LAW (CHAPTER 87, CIVIL PRACTICE AND REMEDIES CODE), AN EQUINE PROFESSIONAL IS NOT LIABLE FOR AN INJURY TO OR THE DEATH OF A PARTICIPANT IN EQUINE ACTIVITIES RESULTING FROM THE INHERENT RISKS OR EQUINE ACTIVITIES.

I consent \_\_\_\_\_ Date: \_\_\_\_\_  
 Signature and/or Signature of Parent/Guardian if Volunteer is under 18 years of age

I do not consent \_\_\_\_\_ Date: \_\_\_\_\_  
 Signature and /or Signature of Parent/Guardian if Volunteer is under 18 years of age

### LIABILITY:

THE UNDERSIGNED VOLUNTEER UNDERSTANDS THAT HE/SHE WILL BE ASSISTING WITH INSTRUCTING RIDERS WITH DISABILITIES IN HORSEBACK RIDING, INVOLVING DIRECT CONTACT WITH HORSES—LEADING, GROOMING, TACKING, ETC., AND THAT NO LIABILITY CAN BE ACCEPTED FOR ACCIDENTS BY ANY OF THE ORGANIZATIONS CONCERNED, INCLUDING DREAM A DREAM THERAPEUTIC HORSEMANSHIP, AND THE VOLUNTEER DOES HEREBY FOREVER RELEASE, ACQUIT, DISCHARGE AND HOLD HARMLESS DREAM A DREAM THERAPEUTIC HORSEMANSHIP, ITS OFFICER, TRUSTEES, AGENTS, EMPLOYEES, HORSE OWNERS, REPRESENTATIVES, SUCCESSORS, OR ASSIGNS BECAUSE OF ANY PERSONAL INJURIES.

I consent \_\_\_\_\_ Date: \_\_\_\_\_  
 Signature and/or Signature of Parent/Guardian if Volunteer is under 18 years of age

I do not consent \_\_\_\_\_ Date: \_\_\_\_\_  
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### PHOTOGRAPHS/FILMS:

The undersigned volunteer hereby grants to Dream A Dream Therapeutic Horsemanship, permission to take or have taken still and moving photographs and films including television pictures of volunteer, and consents and authorizes Dream A Dream Therapeutic Horsemanship, its advertising agencies, news media, and any other persons interested in Dream A Dream Therapeutic Horsemanship, and its work, to use and reproduce the photographs, films, and pictures and circulate and publicize the same by all means including, without limiting the generality of the foregoing, newspapers, television media, brochures, pamphlets, instructional materials, books and clinical materials.

I consent \_\_\_\_\_ Date: \_\_\_\_\_  
 Signature and/or Signature of Parent/Guardian if Volunteer is under 18 years of age

I do not consent \_\_\_\_\_ Date: \_\_\_\_\_  
 Signature and /or Signature of Parent/Guardian if Volunteer is under 18 years of age

### CONFIDENTIALITY:

The undersigned understands that all client information is confidential, and the undersigned will not discuss or make any written reports without prior approval from the Dream A Dream Therapeutic Horsemanship personnel. Any ledgers, logs, reports, etc., will all be reviewed by the Dream A Dream Therapeutic Horsemanship staff and the undersigned WILL NOT use the clients' last names. If you are writing a report for a class, please assign a fictitious name to the client.

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## EMERGENCY RELEASE TREATMENT FORM

Name: \_\_\_\_\_

Parent or Guardian (if under 18): \_\_\_\_\_

Address: \_\_\_\_\_  
(complete if different from front page)

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_

Physician's Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Health care insurance company: \_\_\_\_\_

Policy Number: \_\_\_\_\_

Person to notify in case of an emergency: \_\_\_\_\_

Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Preferred Medical Facility: \_\_\_\_\_

Describe any medical condition requiring special precautions or treatment and any medications and dosages the emergency room physician should be made aware of in case of an emergency:

\_\_\_\_\_  
\_\_\_\_\_

In case of medical emergency, the undersigned authorizes D.A.D.T.H., to provide such medical assistance as D.A.D.T.H. and the physician determine to be necessary.

The undersigned authorizes any licensed physician and/or medical facility to provide any medical or surgical care and/or hospitalization, including anesthetic, they determine necessary or advisable, pending receipt of specific consent from the undersigned or the parent/guardian.

I understand that NO LIABILITY can be accepted by any organization concerned with this instruction, in the event of any accident which may occur.

I consent \_\_\_\_\_ Date: \_\_\_\_\_  
Signature and/or Signature of Parent/Guardian if Volunteer is under 18 years of age

I do not consent \_\_\_\_\_ Date: \_\_\_\_\_  
Signature and /or Signature of Parent/Guardian if Volunteer is under 18 years of age