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

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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 THEREAPEUTIC HORSEMANSHIP, AND THE VOLUNTEER DOES HEREBY FOREVER RELEASE, ACQUIT, DISCHARGE AND HOLD HARMLESS DREAM A DREAM THEREPEUTIC 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: _____
Signature and /or Signature of Parent/Guardian if Volunteer is under 18 years of age

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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.

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I do not consent _____ Date: _____
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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