



# T.H.E. CENTER INC.

**Therapy for Handicapable Equestrians**

P.O. Box 5337, Hemet, CA 92544

(951)-658-7790

Fax (951)-765-6001

[www.t-h-e-center.org](http://www.t-h-e-center.org)

[info@t-h-e-center.org](mailto:info@t-h-e-center.org)

Volunteer

Staff

Board Member

## INFORMATION AND HEALTH HISTORY

### General Information

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

Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

E-mail Address: \_\_\_\_\_

Employer/School: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Phone: (H) \_\_\_\_\_ (C) \_\_\_\_\_ (W) \_\_\_\_\_

Parent/Legal Guardian Name (if under 18 years of age): \_\_\_\_\_

Address (if different from above): \_\_\_\_\_

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

Current Driver's License:  yes  no License Number: \_\_\_\_\_ State \_\_\_\_\_

How did you learn about the program? \_\_\_\_\_

First Date at T.H.E. Center: \_\_\_\_\_ How many years riding horses? \_\_\_\_\_

Have you participated at another Therapeutic Riding Facility?  No  Yes; Facility \_\_\_\_\_

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### **(Consult your physician or local health department if you are not up to date with these shots/tests)**

Recent Medical Tests: Last Tetanus Shot: \_\_\_\_\_ Tuberculosis Test + - Date: \_\_\_\_\_

### Health History

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

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

**Allergies:** \_\_\_\_\_

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

**Medications:** \_\_\_\_\_

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: \_\_\_\_\_



Signature of Parent/Legal Guardian: (if minor) \_\_\_\_\_



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## INFORMATION FORM AND HEALTH HISTORY

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

### **Photo Release**

- I do
- I do not

consent to and authorize the use and reproduction by T.H.E. Center, Inc. (Therapy for Handicapable Equestrians) 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 program.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### **Background Information**

Have you ever been charged with or convicted of a crime?  yes  no If yes, please explain:

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I, \_\_\_\_\_(name) authorize **T.H.E. Center, Inc.** 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.

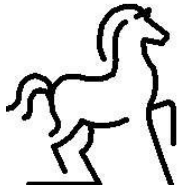
I understand that such access is for the purpose of considering my application as an volunteer/staff, and that I expressly **DO NOT** authorize the **NARHA** Center, its directors, officers, employees, or other volunteers to disseminate this information in any way to any other individual, group, agency, organization, or corporation.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### **Confidentiality Agreement:**

I understand that all information (written and verbal) about participants at this **NAHRA** center is confidential and will not be shared with anyone without the express written consent of the participant and their parent/guardian in the case of a minor.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_



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**AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT FORM**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Phone: (H) \_\_\_\_\_ (C) \_\_\_\_\_ (W) \_\_\_\_\_  
 Physician's Name: \_\_\_\_\_ Medical Facility: \_\_\_\_\_  
 Health Insurance Co: \_\_\_\_\_ Policy #: \_\_\_\_\_  
 Allergies to Medications: \_\_\_\_\_

**In the event of an emergency contact:**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ 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 the agency, I authorize T.H.E. Center, Inc. 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**

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: \_\_\_\_\_

**Non-Consent**

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 T.H.E. Center, Inc. In the event emergency treatment/aid is required, I wish the following procedures to take place: Please write detail on back & be specific.

**NON-CONSENT** Signature: \_\_\_\_\_

Date: \_\_\_\_\_



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## LIABILITY RELEASE

As a volunteer/staff/student/board at T.H.E. Center, Inc. I acknowledge the risks and the potential risks of a horseback riding program. However, I feel the possible benefits to myself and the participants I work with are greater than the risk assumed.

I hereby, intending to be legally bound, for myself, my heirs and assigns, executors or administrators, waive and release forever all claims for damages against T.H.E. Center, Inc. its' Board of Directors, Instructors, Therapists, Aides, Volunteers and/or Employees for any and all injuries and/or losses I may sustain while participating in T.H.E. Center, Inc. program.

If volunteer is under 18 years of age, Parent/Guardian must sign.

Name (Please Print) \_\_\_\_\_

Signature: \_\_\_\_\_

Signature: \_\_\_\_\_

Parent/Guardian – if minor or legal guardian)

Date: \_\_\_\_\_





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Name: \_\_\_\_\_ Phone # \_\_\_\_\_

**AREAS OF INTERESTS**

Please check the areas of interest or knowledge so that we can utilize your expertise in the best possible way at T.H.E. Center.

**PROGRAM**

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Horse Handling    | <input type="checkbox"/> New/willing to learn | <input type="checkbox"/> Years of experience _____ |
| <input type="checkbox"/> Side Walking      | <input type="checkbox"/> New/willing to learn | <input type="checkbox"/> Years of experience _____ |
| <input type="checkbox"/> Stable Management | <input type="checkbox"/> New/willing to learn | <input type="checkbox"/> Years of experience _____ |
| <input type="checkbox"/> Trail Rides       | <input type="checkbox"/> New/willing to learn | <input type="checkbox"/> Years of experience _____ |
| <input type="checkbox"/> Photography       | <input type="checkbox"/> New/willing to learn | <input type="checkbox"/> Years of experience _____ |
| <input type="checkbox"/> Horse Shows       | <input type="checkbox"/> New/willing to learn | <input type="checkbox"/> Years of experience _____ |

**FACILITY**

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Plumbing       | <input type="checkbox"/> New/willing to learn | <input type="checkbox"/> Years of experience _____ |
| <input type="checkbox"/> Electrical     | <input type="checkbox"/> New/willing to learn | <input type="checkbox"/> Years of experience _____ |
| <input type="checkbox"/> Tractoring     | <input type="checkbox"/> New/willing to learn | <input type="checkbox"/> Years of experience _____ |
| <input type="checkbox"/> Weed Abatement | <input type="checkbox"/> New/willing to learn | <input type="checkbox"/> Years of experience _____ |
| <input type="checkbox"/> Gardening      | <input type="checkbox"/> New/willing to learn | <input type="checkbox"/> Years of experience _____ |
| <input type="checkbox"/> Fencing        | <input type="checkbox"/> New/willing to learn | <input type="checkbox"/> Years of experience _____ |
| <input type="checkbox"/> Shelters/Arena | <input type="checkbox"/> New/willing to learn | <input type="checkbox"/> Years of experience _____ |

**FUNDRAISING**

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Special Events  | <input type="checkbox"/> New/willing to learn | <input type="checkbox"/> Years of experience _____ |
| <input type="checkbox"/> Silent Auctions | <input type="checkbox"/> New/willing to learn | <input type="checkbox"/> Years of experience _____ |
| <input type="checkbox"/> Grant Writing   | <input type="checkbox"/> New/willing to learn | <input type="checkbox"/> Years of experience _____ |

**ADMINISTRATION**

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Newsletters           | <input type="checkbox"/> New/willing to learn | <input type="checkbox"/> Years of experience _____ |
| <input type="checkbox"/> Volunteer Coordinator | <input type="checkbox"/> New/willing to learn | <input type="checkbox"/> Years of experience _____ |
| <input type="checkbox"/> Computer              | <input type="checkbox"/> New/willing to learn | <input type="checkbox"/> Years of experience _____ |



If your parent is willing to help in a specific area of expertise, please have them complete this form separately from your form.