Equestrian Program Volunteer Application 2020

Name	Address
City	Zip
Phone	Email
Age:	Date of Birth:
Notify in case of emergency:	
Please list any experience you have with horses:	
Please list any experience you have with disabled children:	
List the days and times you are available:	
Do you have any physical limitations: If yes please explain:	yes / no
Can you walk for 60 minutes and jog short distances? If no, please explain:	yes / no
Given a chance to change sides frequently, can you hold your arms above shoulder height and support a modest weight? If no, please explain:	yes / no
Do you have any other skills which may be of benefit to the volunteer program?	
Please circle the volunteer activities you would be interested in helping with and also whether you have any experience in each area. (Experience is not necessary to indicate an interest you may have)	
Horse groom: grooming, bathing, stall cleaning, and tack maintenance.	Volunteer / Experience
Ground trainer: lounging, turn out, and exercising horses.	Volunteer / Experience
Side-walker/mount leader in riding class: walks alongside a child and or horse.	Volunteer / Experience
Teacher's Aide: assist with children in all aspects of a class	Volunteer / Experience
Facility maintenance: handy person, electrician, fence mender etc.	Volunteer / Experience
Fundraising: event organization, community BBQ, ride-a-thon etc.	Volunteer / Experience
Public Relations: circulation of brochures, flyers, posters, etc.	Volunteer / Experience
Other information you would like to share with us:	

Authorization for Emergency Medical Treatment Form

o Participant o Staff o Volunteer

Name: _____ DOB: _____ Phone: _____

Address: _____

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 participation, or while being on the property of the agency, I authorize Ivey Ranch Park Association 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 necessary by the physician.

Signature_____ Date:_____
Client, Parent or Legal Guardian

Printed name of above signature_____

Ivey Ranch Park Association
Equestrian Program

WAIVER OF LIABILITY FOR STAFF MEMBERS OR VOLUNTEERS

I herby waive any right or cause of action arising as a result of my own or my child's participation in the Ivey Ranch Park Association Equestrian Program from which any liability may or could accrue against Ivey Ranch Park Association, or the officers, staff, volunteers, and associates collectively or individually. Without limiting the generality of the foregoing, I agree that this waiver shall include any rights or causes of action resulting from personal injury to me or damage to my property sustained in connection with my activities for the Ivey Ranch Park Association Equestrian Program.

In consideration of the acceptance of myself or my child's participation in the program listed above, I hereby, for myself, my heirs, executors, administrators, and assignees, release, waive, and/or forever discharge any and all rights and claims for damages that may be suffered by me or my child as a result of preparation for, or participation in, the equestrian program. I recognize the risks associated with my/his/her participation in the program and specifically agree to indemnify and hold harmless Ivey Ranch Park Association; including any members, any employee, all program participating individuals associated with Ivey Ranch Park Association, any promoter, sponsor, or subcontractor whose facilities and/or services are being used for this program, from any and all injuries or damages arising from, or in any way contributed to, my or my child's participation in this program.

I understand that reasonable measures will be taken to safeguard the health and safety of all participants and that I will be notified (or the contact I have listed) as soon as possible in case of any emergency affecting me or my child. In the event I cannot be reached (or the contact I have listed) in an emergency, I hereby authorized the directions listed on the Emergency Medical Treatment Form to be followed.

I also herby authorize and consent that Ivey Ranch Park Association has the right to copyright, publish, use, sell or assign any and all photographic pictures, videotapes and/or sound recordings taken or made of me or the youth mentioned below in which I or the youth mentioned below may be included in whole or part. I grant permission to allow these images and/or recordings to be put to legitimate use at the discretion of Ivey Ranch Park Association. I relinquish all rights, title, or interest to any furnished products, reproductions or facsimiles.

I, the participant, parent, guardian, or legal custodian of the minor participant, do hereby assent to above waiver and release and agree to all terms as stated above.

Participant's Printed Name:_____ D.O.B. _____

Participant's Sex: Male or Female (Please circle one)

Adult Signature:_____ Date:_____

(Self, Parent, or Guardian)

Signatories Printed Name:_____ Relationship:_____

Email:_____ Phone:_____

Address: _____

Emergency Contact:_____ Phone:_____

Relationship:_____

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Bylaw 503 H. Concussion Protocols as Per Ed. Code 49475.(a).(1)

A student-athlete who is suspected of sustaining a concussion or head injury in a practice or game shall be removed from competition at that time for the remainder of the day. A student-athlete who has been removed from play may not return to play until the athlete is evaluated by a licensed health care provider trained in education and management of concussion and receives written clearance to return to play from that health care provider. If a licensed health care provider, trained in education and management of concussion determines that the athlete sustained a concussion or a head injury, the athlete is required to complete a graduated return-to-play protocol of no less than 7 days, from the time of diagnosis, in duration under the supervision of a licensed health care provider. On a yearly basis, a concussion and head injury information sheet shall be signed and returned by all athletes and the athlete's parent or guardian before the athlete's initiating practice or competition.