Champlain Adaptive Mounted Program

57 East Shore Road
South Hero, Vermont 05486
Phone: (802) 372-4087 www.vtchamp.org

Volunteer/Staff Information Form and Health History

General Information

Name: _____ Date: _____

Address _____ email: _____

Date of Birth: _____ Phone: _____ (W) _____

Employer/School: _____

Address: _____

_____

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

_____

How long have you lived in Vermont ? _____

Are you fulfilling a Community Service requirement? _____

For which School or Agency? _____

How did you learn about Champ? _____

These are suggested hours, we are flexible and will adjust hours to fit your availability

Available Times								
9:00 – 11:00• Mon• Tues. Mon		Tues.	Wed. • Thurs Thurs	Fri	Sat			
11:00 – 1:00								
1:00 – 3:00								
3:00 – 5:00								

Previous Horse experience ? ❑ Yes ❑ No

Check areas in which you are interested:

Program	Special Events	Administration	
❑ Lesson Prep			
❑ Horse Handling	❑ Horse Show	❑ Public Relations	❑ Photography/Video
❑ Sidewalking with a Student	❑ Fundraising	❑ Grant Writing	❑ Budget & Finance
❑ Stable Management	❑ Special Olympics	❑ Newsletter	❑ Future Planning
❑ Facility Repairs	❑ Trail Rides	❑ Volunteer Recruitment	

J 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: _____ _

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Health History

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

Recent medical tests: _____Last Tetanus Shot: _____ Tuberculosis Test + = Date _____:
(Consult your physician or local health department if you are not up to date with these shots/tests)

Are you able to jog next to the Horse ❑ Yes ❑ No

Allergies:_____

Medications: _____

Confidentiality Agreement

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

Signature _____ Date _____

Volunteer Liability Release

As a volunteer at the Champlain Adaptive Mounted Program (CHAMP), I acknowledge the risks and potential for risks of a horseback riding program. However, I feel the possible benefits to myself and the clients worked 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 CHAMP, its board of directors, instructors, therapists, volunteers and/or employees of CHAMP at Good Hope Farm and PATH Int. for any and all injuries and /or losses I may sustain while participating in the CHAMP activities. I also understand that under Vermont Law, an equine activity sponsor is not liable for an injury to, or the death of a participant in equine activities resulting from the inherent risks of equine activities that are obvious and necessary, persuant to 12 V.S.A. 1039

Signature _____ Date _____
PRINT NAME BELOW IF SIGNATURE ABOVE IS BY A PARNET OR GUARDIAN FOR A VOLUNTEER UNDER 18

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CHAMP may request you to be part of a promotional press release. For legal reasons we require that you understand and agree to the releases below by filling them out and signing both.

VOLUNTEER_____ DATE OF BIRTH: _____AGE:_____

ADDRESS:_____

CITY / STATE/ ZIP_____

Home Phone_____ Cell #:_____Work Phone:_____

PHOTO RELEASE
❑ I Do
❑ I Do Not

consent to and authorize the use and reproduction by *CHAMP* of any and all photographs and any other audio-visual materials taken of me for promotional use, educational activities, and exhibitions or for any other use for the benefit of the program.

SIGNATURE _____DATE _____
PRINT NAME BELOW IF SIGNATURE IS BY A PARENT OR GUARDIAN RELATIONSHIP

_____ Relationship_____

INFORMATION FOR PRINT RELEASE
❑ I Do
❑ I Do Not

consent to and authorize the use and reproduction of any and all interviews done by members of the press for the purposes of promoting the Champlain Adaptive Mounted Program (*CHAMP*). I will not hold any *CHAMP* instructor or volunteer or the authors or publishers of any article liable for statements they may make about me and my participation in this program based on the information provided in interviews. I further understand that I am participating solely for the promotion and fundraising to benefit the *CHAMP* programs and that there will be no compensation made to me by *CHAMP* or the publishing organizations.

SIGNATURE_____DATE_____
PRINT NAME BELOW IF SIGNATURE IS BY A PARENT OR GUARDIAN RELATIONSHIP

_____ Relationship_____

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Authorization for Emergency Medical Treatment Form

❑ Staff ❑ Volunteer

Name:_____ DOB:_____Phone: _____

Address:_____email ;_____

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 *CHAMP*

I authorize Champlain Adaptive Mounted Program – *CHAMP* 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 presence of center staff

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CHAMP Background Information Form

Background Information

Have you ever been charged with or convicted of a crime? Yes - No
Please explain, _____
_____
_____

I, _____ volunteer/staff, authorize CHAMP 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 applications as an volunteer/ employee, and I expressly DO NOT authorize CHAMP, 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: _____
Current Driver's License Yes - No License Number_____ State _____

It has become evident to us that, in our current social and legal climate, we must ask for background checks on our volunteers and employees. Our riders are members of a vulnerable population and we have an obligation to assure them of a safe and comfortable environment in which they can thrive.

We have never had any indication of problems within our organization. We believe our employees and volunteers are people of the highest caliber and are above reproach. However, we must be able to back this claim with official proof.

We hope you can put yourselves in the position of our riders and their caregivers and understand the need for this requirement. A request for background information is not meant as an insult and should not be taken as such.

We ask you to complete Section II of the Vermont Agency of Human Services Registry Check Form.

Your position as a volunteer or employee is conditional upon receipt of an acceptable report.