



THE RIGHT PATH RIDING ACADEMY
AT QUAIL VALLEY RANCH
"Therapeutic Horseback Riding"
 16620 Old Shamrock Highway Drumright, OK 74030
 (918) 352-4110
rightpathacademy@sbcglobal.net

Volunteer/Staff Information Form and Health History

General Information

Name: _____ Date: _____

Address: _____

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

Best phone number to contact you in case of cancellation: _____

Email address: _____

Employer/School: _____ Address: _____

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

How did you learn about the program? _____

Please list two non-family references: (If minor please have parents list two references)

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

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.

Allergies: _____

Medications: _____

Check areas in which you are interested:

- PROGRAM** Horse Handling Sidewalking with a Student Stable Management Facility Repairs Trail Rides
SPECIAL EVENTS Special Olympics Horse Show Fundraising Public Relations Photography/Video
ADMINISTRATION Newsletter Future Planning Volunteer Recruitment Grant Writing Budget & Finance

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/Guardian if minor: _____

Office Use Only: Training date & type:	Start Date:

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Name: _____

Photo Release

I DO
 DO NOT

consent to and authorize the use and reproduction by The Right Path Riding Academy 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: _____

Signature of Parent/Guardian if minor: _____

Background Information

Have you ever been charged with or convicted of a crime? Yes [] No []

Have you ever had your driver's license suspended? Yes [] No []

Please Explain: _____

I, _____ (volunteer/staff), authorize The Right Path Riding Academy 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 application as an employee/volunteer, and 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: _____

Signature of Parent/Guardian if minor: _____

CURRENT DRIVER'S LICENSE Y N LICENSE NUMBER _____ STATE _____

Volunteer Liability Release

As a volunteer at "The Right Path Riding Academy", I acknowledge the risks and potential for risks of a horseback riding program. However, I feel that the possible benefits to myself and the clients 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 "The Right Path Riding Academy", its board of directors, instructors, therapists, volunteers and/or employees for any and all injuries and/or losses I may sustain while participating in "The Right Path Riding Academy".

Signature: _____ Date: _____

Signature of Parent/Guardian if minor: _____

Confidentiality Agreement

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

Signature: _____ Date: _____

Signature of Parent/Guardian if minor: _____



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Authorization for Emergency Medical Treatment Form

Participant Staff Volunteer

Name: _____ Phone: _____

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 of the agency,

I authorize The Right Path Riding Academy 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: _____
Parent/Guardian if minor: _____

Non-Consent Plan

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 the agency.

- Parent or legal guardian will remain on site at all times during equine assisted activities.
 In the event emergency treatment/aid is required, I wish the following procedure to take place:

Date: _____ Non-Consent Signature: _____
Parent/Guardian if minor: _____