

Therapeutic Riding, Inc. Form #2
3425 E. Morgan Road, Ann Arbor, MI 48108
Volunteer Registration and Emergency Treatment Form

This form is valid until December 31 of the year signed.

No individual can be accepted as a volunteer in Therapeutic Riding Inc. until this form has been completed by his/her parent(s)/guardian or by the individual if he/she is a legally competent adult 18 years of age or older.

Date: _____ New Volunteer Return Volunteer

Volunteer: Full Name _____ Date of Birth _____
Mailing address _____
City _____ State _____ Zip _____ Height _____
Home Phone (____) _____ Cell Phone (____) _____
Work Phone (____) _____ Email _____
Previous experience with horses _____

Parent(s)/Guardian(s) (If under 18): Full Name _____
Mailing address _____
City _____ State _____ Zip _____
Home Phone (____) _____ Cell Phone (____) _____
Work Phone (____) _____ Email _____

Physician: Name _____
Mailing address _____
City _____ State _____ Zip _____ Office Phone (____) _____

Person who should be notified in case of emergency in absence of parent/guardian:
Name _____ Relationship to Volunteer _____
Home Phone (____) _____ Cell Phone (____) _____ Work Phone (____) _____

AUTHORIZATION FOR PURPOSE OF PROVIDING MEDICAL TREATMENT

You are being asked to complete this form to give an appropriate medical facility permission to treat

_____ (*Volunteer's name*) for minor injury or medical problems. In the event of serious injury

or illness, the parent/guardian or person listed above will be contacted; treatment will proceed before contacting them only if the situation is urgent and does not permit delay.

Preferred Medical Facility

Is there a medical condition, allergy, etc., requiring special precaution or treatment? Yes No

If Yes, please describe _____

Medications currently being used? Yes No If Yes, please list name, purpose, and dosage _____

In case of medical emergency: The undersigned authorizes a Therapeutic Riding, Inc. instructor and/or program coordinator to seek any medical and/or surgical treatment necessary for the care of _____ (*Volunteer's name*) who is participating as a volunteer in the Therapeutic Riding Inc. program with parent/guardian permission (if under 18 years old.)

HEALTH INSURANCE

Name of Policyholder/Relationship to Participant _____

Policyholder's address _____

Please attach a photocopy of both sides of your insurance card (Preferred) OR complete the insurance information requested here.

Name and Address of Insurance Company _____

Insurance Company Phone Number (____) _____ **Policy Number** _____

Name of Policyholder's Employer _____

REQUIRED SIGNATURES THIS SECTION MUST BE WITNESSED BEFORE RETURNING

The above designated person(s) is/are hereby authorized to incur medical costs necessary to provide medical treatment for said participant for which we shall be fully responsible. We also authorize the medical facility to release any and all information required to complete insurance claims and also authorize insurance payment directly to the medical facility.

Signature: _____ **Date** _____

Parent(s)/Guardian/Adult Volunteer (Circle appropriate title.)

Witness: _____ **Date** _____

Printed Name of Witness: _____