SuMMit Centre for Therapeutic Riding
2143 Choptank Road, Middletown, DE 19709
(302) 690-7235
Summitcentre@outlook.com

Volunteer Form

Name of Volunteer:_____ Date: _____

Primary Phone:_____ Secondary Phone:_____

Email:_____

Address: _____City:_____State: _____Zip:_____

Business:_____Phone:_____

Parent/Guardian's Name/Address/Phone (if applicable): _____

_____

How did you learn about SuMMit Centre:_____

Check which areas you are interested in:

	Horse Activities		Administration Duties
☐	Headwalker	☐	Property Maintenance
☐	Sidewalker	☐	Marketing & Social Media
☐	Stable Assistant	☐	Fundraising & Outreach

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

Photo Consent Date: Signature: _____

Volunteer, Parent, Guardian:_____

Volunteer, Parent, Guardian:_____

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Volunteer Liability Release

As a volunteer with SuMMit Centre for Therapeutic Riding, I acknowledge the risks and potential for risks of an equine program. However, I feel the possible benefits to myself and the clients I work with are greater than the risk. Thereby, intending to be legally bound, for myself, my heirs and assigns, executors or administrators, released forever all claims for damages against SuMMit Centre, its Board of Directors, instructors, volunteers and/or employees, Blue Diamond Equestrian Center (stable/owner), Rowan Farm (stable/owner) Karen Garland and Kim & Emmett Meier for any and all injuries and/or losses I may sustain while participating with SuMMit Centre for Therapeutic Riding.

Liability Consent Date:_____

Volunteer Signature:_____

Volunteer, Parent, Guardian:_____

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Volunteers Authorization for Emergecny Medical Treatment Form

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 this agency, I authorize SuMMit Centre for Therapeutic Riding, Inc. to:

1. Secure and retain medical treatment and transportation if needed.
2. Release volunteer records upon request to the authorized individual or agency involved in the medical emergency treatment.

Volunteers Name: _____ Phone: _____

Address: _____ City/State: _____ Zip: _____

In the event of an emergency:

Primary Contact: _____ Phone: _____

Secondary Contact: _____ Phone: _____

Physician's Name: _____ Phone: _____

Preferred Medical Facility: _____

Health Insurance Co.: _____ Policy #: _____

Any allergies, important information or specific instructions that will need to be known in the event of an emergency?

_____

_____

_____

_____

_____

Consent Plan

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 below is unable to be reached.

Date:_____ Consent Signature:_____

Volunteer, Parent or Guardian:_____

Print Name:_____Phone:_____

Address:_____

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. In the event emergency treatment/aid is required, I wish the following procedures to take place:

Date:_____ Consent Signature:_____

Volunteer, Parent or Guardian:_____

Print Name:_____Phone:_____

Address:_____