

# *Whispers of Hope Horse Farm*

## **New Volunteer Questionnaire**

Name \_\_\_\_\_

Date \_\_\_\_\_

Phone Number \_\_\_\_\_

How did you hear about Whispers of Hope Horse Farm?

Have you volunteered before at Whispers of Hope Horse Farm?     YES    NO

Why are you interested in volunteering with Whispers of Hope Horse Farm?

Describe your experience with horses: \_\_\_\_\_

Are you interested in helping     outside in the barn     inside the office?

What would you like to help with?

What days and times are you available to volunteer?

### **Office use Only**

**New Volunteer**

**Volunteer #** \_\_\_\_\_

- New Volunteer Questionnaire
- Volunteer Registration Form
- Volunteer Liability Form
- Schedule Volunteer times
- First time volunteering - Date \_\_\_\_\_
- Volunteer has been posted to database -Date \_\_\_\_\_
- New Folder has been made

# Volunteer Registration Form

Today's Date: \_\_\_\_\_

## Personal Information

Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_

E-mail: \_\_\_\_\_

Address: \_\_\_\_\_ Home Phone :(\_\_\_\_) \_\_\_\_\_

City: \_\_\_\_\_ State \_\_\_\_\_ Zip: \_\_\_\_\_

Occupation: \_\_\_\_\_

Employer/School: \_\_\_\_\_

Do you have any physical limitations? Describe: \_\_\_\_\_

Parent/guardian/caregiver name: \_\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_\_

May we contact you at work?  Yes  No Work Phone: (\_\_\_\_) \_\_\_\_\_

## General Information

Whispers of Hope Horse Handlers must know how to groom, tack, lead horses and have knowledge of horse temperament. Do you qualify as a Horse Handler or Leader? \_\_\_\_\_

## Interest Areas

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Side walker                  | <input type="checkbox"/> Feeding Horses    | <input type="checkbox"/> Strategic Planning        |
| <input type="checkbox"/> Special Olympics Events      | <input type="checkbox"/> Stable Care       | <input type="checkbox"/> Special Events            |
| <input type="checkbox"/> Coordinating Volunteers      | <input type="checkbox"/> Equipment Care    | <input type="checkbox"/> Public Speaking/Relations |
| <input type="checkbox"/> Preparing Posters/Signs/Etc. | <input type="checkbox"/> Hay Hauling       | <input type="checkbox"/> Committee Participation   |
| <input type="checkbox"/> Office Administration        | <input type="checkbox"/> Ranch Maintenance | <input type="checkbox"/> Marketing/Advertising     |

## Skill Areas

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Horse Leader/Handler | <input type="checkbox"/> Computer Projects | <input type="checkbox"/> Fund Raising          |
| <input type="checkbox"/> Training Horses      | <input type="checkbox"/> Fence Work        | <input type="checkbox"/> Board Recruitment     |
| <input type="checkbox"/> Welding              | <input type="checkbox"/> Carpentry         | <input type="checkbox"/> Facility Improvements |
| <input type="checkbox"/> Plumbing             | <input type="checkbox"/> Electrical Work   |  |

Please list any other information about yourself, which you feel could be useful to the Program.

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## Confidentiality Policy

WOHHF shall preserve the right to confidentiality for all individual in its program. No one associated with WOHHF will reveal any medical, social, referral, personal, and financial information regarding any client or other person associated with WOHHF to anyone unless required by court order. This policy applies to clients, staff, contractors, temporary employees, volunteers and board members. Failure to comply can result in reprimand, loss of certain job responsibilities, or termination.

I understand and will observe the confidentiality policy of Whispers of Hope Horse Farm.

Signed \_\_\_\_\_ date \_\_\_\_\_

**Please return this form completed to office.**

*Whispers of Hope Horse Farm*

# Volunteer Liability Form

**UNDER TEXAS LAW (Chapter 87, Civil Practice and Remedies code), an equine professional is not liable for an injury to or the death of a participant in equine activities resulting from inherent risks of equine activity.**

I wish to participate or have my child or ward participate in the Whispers of Hope Horse Farm Program and I hereby acknowledge that I have legal authority to enroll said person in this program. I acknowledge the risks and possible risks of horseback riding, however, I feel that the potential benefits to myself, my child or my ward are greater than the risk assumed. I hereby, intending to be legally bound for myself, my heirs, assigns, executors, or administrators, waive and release forever all claims for damages against Whispers of Hope Horse Farm, its Board of Directors, Officers, Agents, Instructors, Therapists, Aides, Volunteers, Employees and Owners of horses for any and all injuries, illnesses, and/or losses sustained by myself/my son/my daughter/my ward or my horse, while participating in Whispers of Hope Horse Farm Programs on site or away. I agree to indemnify Whispers of Hope Horse Farm for any and all claims arising directly or indirectly out of my use of Whispers of Hope Horse Farm horses, equipment or facilities.

Volunteer (over 18) or Parent of Volunteer: \_\_\_\_\_ Date \_\_\_\_\_

**Photo Release:** I hereby authorize the use and reproduction by Whispers of Hope Horse Farm of any and all photographs and any other audiovisual materials taken of me/my son/my daughter/my ward for promotional printed material, educational activities or for any other use for the benefit of the program, with the understanding that discretion will be used at all times.

Volunteer's Name (over 18) or Parent of Volunteer: \_\_\_\_\_ Date: \_\_\_\_\_

## Emergency Medical Form

Volunteer's Name: \_\_\_\_\_ Parent/Guardian: \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_

Physician's Name: \_\_\_\_\_

Insurance Carrier: \_\_\_\_\_ Policy Number: \_\_\_\_\_

Preferred Medical Facility: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_

Relationship: \_\_\_\_\_ Day Ph: (\_\_\_\_) \_\_\_\_\_ Eve Ph: (\_\_\_\_) \_\_\_\_\_

Describe any medical conditions requiring special precautions or treatment and/or medications including dosage.

None or describe: \_\_\_\_\_

I, \_\_\_\_\_ ("Volunteer Name"), am over 18 years of age and fully competent to sign this Emergency Medical Form, which I have read and understand, or, **if under age**, Volunteer has obtained the signature of his/her parent/ guardian, who, by such signature, represents he/she has read and understands this form. No person can be a Volunteer until this form is completed.

In case of medical emergency or necessity, Volunteer authorizes Whispers of Hope to seek or provide for Volunteer such medical assistance as may be necessary or advisable and further authorizes Whispers of Hope to seek the assistance of any physician or medical facility to provide any medical/surgical care, including but not limited to, hospitalization, with such treatment to include anesthesia as necessary or advisable, that the physician or medical facility deem or determines to be necessary or advisable, pending receipt by the physician or medical facility of any other consent to treatment from or on behalf of Volunteer.

Riding instruction will be under strict supervision, and, although every effort will be made to avoid any accident, Volunteer understand that **NO LIABILITY** can be accepted by any of the organizations concerned, including Whispers of Hope Horse Farm and the facility, in the event such accident may occur. In the event any provision of this form is determined to be unenforceable, all other provisions shall remain in full force and effect.

### **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: \_\_\_\_\_ Print Name: \_\_\_\_\_

### **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 service or while being on the property of the agency. In the event emergency treatment/aid is required, I wish the following procedures takes place: \_\_\_\_\_

Date: \_\_\_\_\_ Consent Signature: \_\_\_\_\_ Print Name: \_\_\_\_\_

**Please return this form completed to office.**