SUNCATCHER
Therapeutic Riding Academy, Inc.
P O Box 3975
Rapid City, SD 57709

SunCatcherRiding@gmail.com **www.suncatchertra.org**

RELEASE FORMS
Attach Volunteer Registration and Health Information

Volunteer's Name_____ **Date**_____

Publicity Release: I hereby **do consent**_____/ **do not consent** _____ to give permission for SunCatcher to use any photographs or audio/visual materials for promotion, education, publication or exhibition for the purposes of conveying information concerning the above named applicant and/or SunCatcher Therapeutic Riding Academy, Inc.

_____ _____ _____
signature of parent, legal guardian, volunteer/staff if own guardian, or authorized person witness date

Liability Release: I acknowledge the risks and potential risks of horseback riding, unmounted equine activities, driving, vaulting and other equine events. However, I feel that the possible benefits to the participant, and to myself as a volunteer/staff member, are greater than the risk assumed. I hereby, intending to be legally bound, for myself, my heir and assigns, executors or administrators, waive and release forever all claims for damages against SunCatcher Therapeutic Riding Academy, Inc., its Board of Directors, staff, consultants, and volunteers but not limited thereto, for any and all injuries and/or losses which may be sustained while volunteering or working at SunCatcher Therapeutic Riding Academy, Inc.

_____ _____ _____
signature of parent, legal guardian, volunteer/staff if own guardian, or authorized person witness date

Background Information

Have you ever been charged with or convicted of a crime? No Yes; Please explain_____

_____

_____

I, _____(volunteer), authorize SunCatcher Therapeutic Riding Academy, Inc. to receive information from any law enforcement agency, including police departments and sheriff's departments, of the state or any other state or federal government, to the extent permitted by state and federal laws, 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.

I understand that such access is for the purpose of considering my application as a volunteer/employee, and that I expressly DO NOT authorize SunCatcher Therapeutic Riding Academy, Inc., 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, legal guardian, volunteer/staff if own guardian, or authorized person)

CURRENT DRIVER'S LICENSE Yes No LICENSE NUMBER_____STATE_____

Authorization for Emergency Medical Treatment Form

I hereby give permission for the applicant as named below, that in the event emergency medical aid/treatment is required due to illness or injury during the process of volunteering/working, or while being on the property of the agency, I authorize SunCatcher 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.

Volunteer's Name_____ Phone_____
Address_____
Please list two people who may be contacted in case of emergency.
Name_____ Phone_____
Name_____ Phone_____
Physician's Name_____
Preferred Medical Facility_____
Health Insurance Co._____ Policy #_____

☐ **Consent Plan:** This authorization includes x-ray, surgery, hospitalization, medication and any treatment procedure deemed "life saving" by the physician. This provision will be invoked only if the person(s) listed as guardian or emergency contacts is (are) unable to be reached. **(signature required)**

OR

☐ **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 volunteering/working with SunCatcher TRA 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:_____

_____
signature of parent, legal guardian, applicant if own guardian, or authorized person

_____ 
witness date

Name_____
Phone(s)_____
Address_____

For Office Use Only:

App Rec'd:_____
Complete?_____
Ref by:_____
Vol: New Current Past
Data Entry:
CS SpS DB Sch'd Conf'd
Comments: _____