O.A.T.S.
Volunteer Registration Form

Name:		Birth Date:
Address:	City:	Zip:
Home Phone:	Cell Phone:	
Gender: ☐ M ☐ F	Email Address:	
Parent/Guardian (*if under 18*):		
Address, if different from above:		
Home Phone:	Cell Phone:	
How did you learn about O.A.T.S.?		Date:

☐ I am here as a volunteer for a one- time event (Group Name): _____

Tell us how you would like to assist our organization (i.e. horse handling, side-walking, fund raising, facility repairs, etc.):

Days / Times You are Available to Volunteer:

Health & Activity Information

Do you have any allergies?	Are you allergic to any medication?
Physical Limitations or Medical Conditions?	
Are you comfortable working with horses & other animals? ☐ Yes ☐ No Please list any experiences that you have had with animals:	
Do you have any experience working with people with disabilities? ☐ Yes ☐ No If yes, please explain:	

Photo Release

I hereby consent to and authorize the use and reproduction by O.A.T.S. of any and all photographs and any other audio/visual materials taken of me/my child/my ward for promotional printed material, educational activities or any other use for the benefit of O.A.T.S programs. ☐ Yes ☐ No

Initials: *(Parent or Guardian, if under 18)*: Date:

Personal Background & Information Release

Have you ever been **charged** with or **convicted** of a crime? ☐ Yes ☐ No *If yes, please explain*:

I, , authorize O.A.T.S. 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 against children or animals. I understand that such access is for the purpose of considering my applications as an employee/volunteer and the I expressly DO NOT authorize O.A.T.S., its directors, officers, employees, or other volunteers to disseminate this information in any way to any other individual, group, agency, organization, or corporation.

Signature: *(Parent or Guardian, if under 18)*:
Printed Name: Date:

Do you have a current Driver's License: ☐ Yes ☐ No License # & State:

Confidentiality Agreement

I understand that all information (written and verbal) about O.A.T.S. participants 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: *(Parent or Guardian, if under 18)*:
Printed Name: Date:

Liability Release and Michigan Equine Activity Liability Act Warning

I would like to participate in the O.A.T.S. riding program. I acknowledge the risks and dangers, together with potentials risks and dangers of horseback riding. However, I think that the possible benefits to myself/my child/my ward are greater than the risks assumed. I have read the warning mandated by the Michigan Equine Activity Liability Act and I understand that under the Michigan Equine Activity Liability Act, an equine professional is not liable for an injury to or the death of a participant in an equine activity resulting from an inherent risk of equine activity.

I hereby, intending to be legally bound, for myself, my heirs and assigns, executors, administrators or personal representatives, waive and release forever all claims for damages against O.A.T.S., its Board of Directors, Instructors, Therapists, Aides, Volunteers and/or Employees for any and all injuries and/or losses that I/my son/my daughter/my ward may sustain while participating in O.A.T.S. activities or upon the O.A.T.S. premises.

Signature: *(Parent or Guardian, if under 18):*
Printed Name: Date:

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www.OATShrh.org

Authorization for Emergency Medical Treatment

*You **must** sign either "Consent Plan" or "Non-Consent Plan"*

In the event that emergency medical aid and/or treatment is required due to illness or injury while volunteering or while being on the premises of O.A.T.S., I authorize O.A.T.S.:

- To secure and retain medical treatment and transportation, if needed.
- To release client records, upon request, to the authorized individual or agency involved in the emergency medical treatment.

Emergency Contact:	Phone:
Secondary Emergency Contact:	Phone:
Preferred Medical Facility:	
Health Insurance:	Policy Number:

☐ CONSENT – I DO give my consent for emergency medical treatment. This authorization includes x-ray, surgery, hospitalization, medication and any treatment or procedure deemed "lifesaving" by the healthcare provider.

☐ NON-CONSENT - I DO NOT give my consent for emergency medical aid and/or treatment in case of illness or injury while volunteering or while being on the premises of O.A.T.S. In the event that emergency treatment or aid is required, I wish the following to take place: (*please fill in your expressed directions*)

Signature (*Parent or Guardian, if under 18*):
Printed Name: Date:

Please Note:

- In the event that a class or event must be cancelled, every effort will be made to notify our volunteers. Primary notification will be sent as a group message via email.

- If you are volunteering and in need of Community Service Hours, you will be responsible for filling out and submitting the necessary paperwork for signature each time you volunteer. O.A.T.S. cannot document your hours unless this log is completed.

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