



3145 High Bridge Rd • Wilmore, KY 40390  
859-519-0471 • [www.StepsAndStridesKY.org](http://www.StepsAndStridesKY.org)

**Volunteer Information Form**

Name \_\_\_\_\_

Address \_\_\_\_\_

Phone # \_\_\_\_\_ Age \_\_\_\_\_

Email \_\_\_\_\_

Areas interested in volunteering:

\_\_\_\_ Side walking with student (greatest need)

\_\_\_\_ Barn Chores

\_\_\_\_ Horse Care

\_\_\_\_ Instructor's Asst.

\_\_\_\_ Fundraising

\_\_\_\_ Grant Writing

\_\_\_\_ Photography

## Liability Release

\_\_\_\_\_ (client's name) would like to participate in **Steps and Strides Equestrian Services, Inc.** program. I acknowledge the risks and potential for risks of horseback riding. However, I feel the possible benefits to myself/my son/my daughter/my ward are greater than the risk assumed. I hereby, intending to be legally bound, for myself, my heirs and assigns, executors or administrators, waive and release forever all claims and damages against **Steps and Strides Equestrian Services, Inc.**, its Board of Directors, Instructors, Therapists, Aides, Volunteers and/or Employees for any and all injuries and/or losses I/my son/my daughter/my ward may sustain while participating with **Steps and Strides Equestrian Services, Inc.**

Date \_\_\_\_\_ Signature \_\_\_\_\_  
Client, Parent or Guardian

## Photo Release

I hereby consent to and authorize the use and reproduction by Steps and Strides Equestrian Services, Inc. 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 any other use for the benefit of the program.

Date \_\_\_\_\_ Signature \_\_\_\_\_  
Client, Parent or Guardian

Volunteer Authorization for Emergency Medical Treatment

In the event emergency medical aid/treatment is required due to illness or injury during the process of volunteering while being on the property of the agency (3145 High Bridge Rd, Wilmore, KY) I authorize Steps and Strides Equestrian Services to:

- 1) Secure and retain medical treatment and transportation I need.
- 2) Release client records upon request to authorized individual or agency involved in the medical treatment.

Volunteer's Name \_\_\_\_\_

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

Address \_\_\_\_\_

Emergency Contact Name and Phone Number

1) \_\_\_\_\_

2) \_\_\_\_\_

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

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

Select one of following plans:

Consent Plan

\_\_\_\_\_ This authorization includes x-rays, surgery, hospitalization, medication, any treatment procedure deemed "life-saving" by the physician.

Date \_\_\_\_\_

Consent Signature \_\_\_\_\_

Parent/Guardian, if under 18 \_\_\_\_\_

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/providing services while being on the property of the Steps and Strides Equestrian Services. In the event, emergency treatment/aid is required I wish the following procedure to take place.

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Date \_\_\_\_\_

Signature \_\_\_\_\_

Parent/Guardian, if under 18 \_\_\_\_\_

Print Name \_\_\_\_\_

Address \_\_\_\_\_