simple changes

THERAPEUTIC RIDING CENTER

Volunteer Forms

Lorton Location

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Mail To:
Simple Changes
P.O. Box 991
Lorton, VA 22199

Volunteer/Staff Confidentiality Agreement

Volunteer/Staff Name:_____

Confidentiality Policy/Statement

1. Riders and their families, staff members, and volunteers have a right to privacy that gives them control over the dissemination of their medical or other sensitive information. Simple Changes, Inc. shall preserve the right of confidentiality for all individuals in its program.
2. The staff shall keep confidential all medical, social, referral, personal and financial information regarding a person and his/her family. Any person who accidentally obtains such information must not disclose it to anyone without proper authorization.
3. Anyone who works or volunteers for, or provides services to, Simple Changes, Inc. is bound by the confidentiality policy, including but not limited to: full- and part-time staff, independent contractors, temporary employees, volunteers, and board members.
4. A person must be over the age of 18 to give consent for disclosure of medical or sensitive information. For anyone under the age of 18, only parent(s), legal guardian(s) or other legal representatives may give consent for disclosure. Adults with developmental disabilities are presumed legally competent to give or deny disclosure unless they have been adjudicated incompetent to make this type of health care decision. If a substitute decision maker has been appointed, written consent must be obtained from that individual.
5. Disclosure of private or sensitive information will not be given out without a person's consent based on a *perceived* need to protect staff or anyone else from possible exposure through casual contact. EVERYONE should commonly practice infection control procedures with all riders and volunteers under the assumption that anyone could have HIV, hepatitis, or other blood-borne diseases. Casual contact poses NO RISK of transmission of diseases such as HIV.
6. Information will be disclosed to outside agencies or individuals only with the specific written consent of the rider or client (or volunteers due to a medical emergency).
7. Breach of this confidentiality policy may result in reprimand, loss of certain job/volunteer responsibilities, or termination of services/employment, to be determined by the Program Director, Executive Director, and/or Board of Directors based on the severity of the breach.

Other grounds for dismissal of volunteers or staff include, but are not limited to:

1) The use of drugs or alcohol on the grounds or at a Simple Changes event, 2) Verbal or physical abuse or sexual harassment or other inappropriate behavior toward participants or other volunteers or staff members, 3) Mistreatment of the horses or other animals at Simple Changes 4) The expression of vulgar language, "off-color" jokes, or disrespectful language, 5) Frequent missed "work" or volunteer times, without prior explanation, 6) Abuse of phone privileges, 7) Smoking in prohibited areas.

I have read, I understand, and I will follow the guidelines of the confidentiality policy and volunteer/staff conduct at Simple Changes, Inc. (Parents/legal guardians must sign for children under 18 or wards of the court. Both parents/guardians must sign below if there is joint or shared custody.)

Signature: _____ Date: _____

Staff, Volunteer (if over 18), Parent or Legal Guardian

Subsequent Year Initials: _____ Date: _____ Subsequent Year Initials: _____ Date: _____

Participant (if over 18), Parent or Legal Guardian — Participant (if over 18), Parent or Legal Guardian

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Volunteer Application/ Criminal History

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GENERAL INFORMATION

Volunteer Name:_____ DOB:_____

Age: _____ Gender: M F Home #_____ Cell #_____

Address: _____ City: _____ State: _____ Zip: _____

E-mail Address_____ School_____

Parent/Guardian's Name (if under 18):

1. _____ Relation: _____

2. _____ Relation: _____

Volunteer or Parent/Guardian's Employer: _____

Job Title: _____ Work #: _____ext._____

How did you hear about the program? _____

I understand that the information provided above is accurate to the best of my knowledge. I know of no reason why I should not participate in this center's program.

Signature: _____ **Date**: _____
Staff, Volunteer (if over 18), Parent or Legal Guardian

Subsequent Year Initials: _____ Date: _____ Subsequent Year Initials: _____ Date: _____
Participant (if over 18), Parent or Legal Guardian Participant (if over 18), Parent or Legal Guardian

CRIMINAL HISTORY

Have you ever been charged with or convicted of a crime? Y N; **If Yes attach a sheet explaining**.

I, _____ (volunteer/staff), authorize Simple Changes, Inc. 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 upon children or animals. I understand that such access is for the purpose of considering my application as an employee/volunteer, and that I expressly DO NOT authorize Simple Changes, 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: _____
Staff, Volunteer (if over 18), Parent or Legal Guardian

Subsequent Year Initials: _____ Date: _____ Subsequent Year Initials: _____ Date: _____
Participant (if over 18), Parent or Legal Guardian Participant (if over 18), Parent or Legal Guardian

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Volunteer Health History/Liability Release/Photo Consent

HEALTH HISTORY

Recent medical test**:** **Last Tetanus Shot**: _____
(Consult your physician or local health department if you are not up to date with these shots/tests)

Please describe your current health status, particularly regarding the physical/emotional demands of working in an equine assisted program. Address fitness, cardiac, respiratory, bone or joint function, recent hospitalizations, surgeries, or lifestyle changes.

_____
_____

Medications and Allergies: _____
_____

LIABILITY RELEASE

Volunteer/Staff Name: _____would like to take part in activities at Simple Changes, Inc. I acknowledge the risks and potential for risks of horseback riding and related activities. However, I feel that the possible benefits to me/ my son/ my daughter/ my ward/my guests are greater than the risk assumed. I hereby, intend to be legally bound for myself/ my heirs and assigns, executors or administrators, waive and release forever all claims for damages against Simple Changes, Inc., its Board of Directors, Instructors, Therapists, Aides, Volunteers, Employees, Contributors, Horse Owners, Bureau of Land Management, and/or C.A.S. (The Stables at Meadowood), for any and all Injuries and/or losses I/ my son/ my daughter/ my ward/my guests may sustain while participating in activities at Simple Changes, Inc.

Signature: _____ Date: _____
Staff/Volunteer (if over 18), Parent or Legal Guardian

Subsequent Year Initials: _____ Date: _____ Subsequent Year Initials: _____ Date:_____
Participant (if over 18), Parent or Legal Guardian Participant (if over 18), Parent or Legal Guardian

PHOTO RELEASE

I ☐ **DO** ☐ **DO NOT** consent to and authorize the use and reproduction by Simple Changes, Inc. of any and all photographs and any other audio/visual materials taken of me/ my son/ my daughter/ my ward/my guests for promotional material, educational activities, exhibitions or for any other use for the benefit of Simple Changes, Inc., the Therapeutic Riding Association of Virginia, the Professional Association of Therapeutic Horsemanship International, The Bureau of Land Management, or the Stables at Meadowood.

Signature: _____ **Date**: _____
Participant (if over 18), Parent or Legal Guardian

Subsequent Year Initials: _____ Date: _____ Subsequent Year Initials: _____ Date: _____
Participant (if over 18), Parent or Legal Guardian Participant (if over 18), Parent or Legal Guardian

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Authorization for Emergency Medical Treatment

Name: _____ DOB: _____ Phone: _____

Address: _____

Health Insurance Company: _____ Policy #:_____

Physician's Name:_____ Physician's Phone:_____

Allergies to medications: _____

Current medications: _____

In the event of an emergency, contact:

1. Name: _____ Relation: _____ Phone: _____

2. Name: _____ Relation: _____ Phone: _____

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 the agency, I authorize Simple Changes, Inc. 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.

☐ 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(s) above is unable to be reached.

Signature: _____ Date: _____
Participant (if over 18), Parent or Legal Guardian

Subsequent Year Initials: _____ Date: _____ Subsequent Year Initials: _____ Date: _____
Participant (if over 18), Parent or Legal Guardian — Participant (if over 18), Parent or Legal Guardian

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 receiving services or while being on the property of the agency.
☐ Parent or legal guardian will remain on site at all times during equine assisted activities
☐ In the event emergency treatment/aid is required, I wish the following procedure to take place:
_____
_____

Signature: _____ Date: _____
Participant (if over 18), Parent or Legal Guardian