



## CHAMPLIAN ADAPTIVE MOUNTED PROGRAM

57 East Shore Road, South Hero, VT 05486

802.372.4087 [www.vtchamp.org](http://www.vtchamp.org)

### *Volunteer / Staff Information Form and Health History*

#### General Information

Name \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_ Cell#: \_\_\_\_\_

DOB: \_\_\_\_\_ Age: \_\_\_\_\_

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

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Parent/Legal Guardian (if under 18) Name: \_\_\_\_\_ Phone \_\_\_\_\_

Address (if different from above): \_\_\_\_\_

How long have you lived in Vermont? \_\_\_\_\_

Are you fulfilling a Community Service requirement? Y/N

If yes, for which school or agency? \_\_\_\_\_

How did you learn about CHAMP? \_\_\_\_\_

Do you have previous horse experience? \_\_\_\_\_

#### Volunteer interests

Please indicate all areas of interest to you:

##### CHAMP Program

- ☐ Grooming / tacking horses
- ☐ Sidewalking with CHAMP riders
- ☐ Assisting with morning barn chores
- ☐ Helping with facility repairs and maintenance
- ☐ Other: Please describe: \_\_\_\_\_

##### Special events / administration

- ☐ Fundraising events
- ☐ Grant writing
- ☐ Photography / videography
- ☐ Public relations

What days/ times are you available to volunteer? \_\_\_\_\_

\_\_\_\_\_



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### Health History

#### Vaccinations

Are you fully vaccinated for Covid-19? Yes \_\_\_\_\_. No \_\_\_\_\_ *Proof of Covid-19 vaccination must be provided.*

When was your last tetanus shot? \_\_\_\_\_

*Please consult your physician or health department if you are not up to date on these vaccinations.*

Have you ever tested positive for Tuberculosis? Yes. \_\_\_\_ No. \_\_\_\_ If yes, when was your last test? \_\_\_\_\_

#### General Health

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 issues.

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Are you able to jog next to a trotting horse? Yes \_\_\_\_\_. No \_\_\_\_\_

Allergies \_\_\_\_\_

Medications \_\_\_\_\_

### Confidentiality Agreement

I understand that all information (written or verbal) about participants at CHAMP is confidential and will not be shared with anyone without express written consent of the participant and/or their parent or guardian in the case of a minor.

Signature \_\_\_\_\_ Date: \_\_\_\_\_

### Liability Release

As a volunteer at the Champlain Adaptive Mounted Program (CHAMP), I acknowledge the risks and potential for risks of a horseback riding program, however, I feel that the possible benefits to myself and the clients worked with are greater than the risks assumed. I hereby, intending to be legally bound, for myself, my heirs and assigns, executors or administrators, waive and release forever all claims for damages against CHAMP at Good Hope Farm, its board of directors, instructors, therapists, volunteers and/or employees; and PATH International; for any and all injuries and/or losses I/my son/my daughter/my ward may sustain while participating in Equine activities. I also understand that under Vermont Law, an Equine activity sponsor is not liable for an injury to, or the death of a participant in equine activities resulting from the inherent risks of equine activities that are obvious and necessary, pursuant to 12 V.S.A. 1039.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print name below if signature is by a parent or guardian – for participants under age 18



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### Authorization for Emergency Medical Treatment

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Phone : \_\_\_\_\_

Address: \_\_\_\_\_

Physician's Name: \_\_\_\_\_ Preferred Medical Facility \_\_\_\_\_

Health Insurance Company: \_\_\_\_\_ Policy No. \_\_\_\_\_

Allergies to Medications \_\_\_\_\_

Current Medications \_\_\_\_\_

In the event of an emergency contact:

Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Phone: \_\_\_\_\_

### Consent Plan

In the event emergency medical aid/treatment is required due to illness or injury during the process of receiving services, or while on the property, I authorize Champ at Good Hope Farm (Champ) to:

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

This authorization includes X-ray, surgery, hospitalization, medication and any treatment procedure deemed "life-saving" by the physician or emergency medical personnel.

This provision will only be invoked if the Emergency Contact persons above are unable to be reached.

Signature of Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_



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CHAMP may request you to be part of a promotional press release. For legal reasons, we require that you understand and agree to the releases below by filling them out and signing both.

Participant: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_

Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

### PHOTO RELEASE

- ☐ I do  
☐ I do not

consent to and authorize the use and preproduction by CHAMP of any and all photographs and any other audio-visual materials taken of me/my son/my daughter/my ward for promotional use, educational activities, and exhibitions and for any other use for the benefit of the program.

SIGNATURE \_\_\_\_\_ Date: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship \_\_\_\_\_

*Print name above if signature is by a parent or guardian relationship*

### INFORMATION FOR PRINT RELEASE

- ☐ I do  
☐ I do not

consent to and authorize the use and reproduction by CHAMP of any and all interviews done by members of the press for purposes of promoting the Champlain Adaptive Mounted Program – CHAMP. I will not hold any CHAMP instructor or volunteer or the authors or publishers of any article liable for statements they may make about me and my participation in this program based on the information provided in interviews. I further understand that I am participating solely for the promotion and fundraising to benefit the CHAMP programs and that there will be no compensation made to me by CHAMP or the publishing organizations.

SIGNATURE \_\_\_\_\_ Date: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship \_\_\_\_\_

*Print name above if signature is by a parent or guardian relationship*



## ***CHAMPLIAN ADAPTIVE MOUNTED PROGRAM***

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### **CHAMP Background Information Form**

#### **Background Information**

Have you ever been charged with or convicted of a crime? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please explain: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

I, \_\_\_\_\_ volunteer / staff, authorize CHAMP to receive information from any law enforcement agency, including police departments and sheriff's departments, of this state or any other state of 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 such access is for the purpose of considering my applications as a volunteer / employee, and I expressly DO NOT authorize CHAMP, 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: \_\_\_\_\_

Current Driver's License Yes \_\_\_\_\_ No \_\_\_\_\_. License Number \_\_\_\_\_ State: \_\_\_\_\_

#### **Background Check**

It has become evident to us that, in our current social and legal climate, we must ask for background checks on our volunteers and employees. Our riders are members of a vulnerable population and we have an obligation to assure them of a safe and comfortable environment in which they can thrive.

We have never had any indication of problems within our organization. We believe our employees and volunteers are people of the highest caliber and are above reproach. However, we must be able to back this claim with official proof.

We hope that you can put yourselves in the position of our riders and their caregivers and understand the need for this requirement. A request for background information is not meant as an insult and should not be taken as such.

**We ask that you complete Section II of the Vermont Agency of Human Services Registry Check Form.**

Your position as a volunteer of employee is conditional upon receipt of an acceptable report.