Last Name:_____, First Name:_____

VOLUNTEER REGISTRATION AND RELEASE FORM

Thank you for your interest in volunteering at Hope Therapy, Inc. You may fill this form out on line or you may print this form and fill it out. Please complete each of the attached five pages. Please sign were applicable. If you are a minor under the age of 18, this form must be signed by your parent or legal guardian where applicable. This form must be presented at the start of your orientation appointment. If this form is not presented at your initial orientation, you will not be permitted to attend the scheduled orientation and will be rescheduled for another time.

1591 Big Branch Road
Middleburg, FL 32068
(904) 291-6784
hopetherapy.org

Volunteer Registration and Release Form

Registration:

Name_____ Date_____

Address _____

_____

E-Mail Address_____ Date of Birth_____

Mobile_____ Home_____ Work_____

School or Employeer_____

Parent/Legal Guardian_____

Address _____

_____

(A legal parent/guardian must sign all areas of this form on behalf of a minor child)

Highest Level of Education Reached_____

Other Organizations where you have volunteered_____

First Aid Certifications (if applicable)_____

Valid Driver's License Number(if applicable)_____

In case of emergency contact:

#1 Name_____ Phone_____

#2 Name_____ Phone_____

Physicians Name_____

Preferred Medical Facility_____

Health Insurance_____

Staff Notes Only

Health History:

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

I have the following limitations, restrictions, or concerns about my physical or emotional status while performing volunteer activities on behalf of Hope Therapy, Inc.

_____

_____

Known Allergies_____

Current Medications_____

Last Tetanus Shot Date_____

(Please consult your physician or local health department if you are not up to date with tetanus shots.)

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 as a volunteer with Hope Therapy, Inc.

_____ _____

SIGNATURE (Volunteer/Parent or Guardian) Date

Emergency Medical Treatment: (Please check and sign only one treatment plan below.)

❒ **CONSENT PLAN** – I give my consent for emergency medical treatment/aid in the case of illness or injury while performing volunteer duties on behalf of Hope Therapy, Inc. This authorization may include medical treatment and transportation if needed, x-ray, surgery, hospitalization, medication, and any treatment procedure deemed "life-saving" by the physician. Release of client records upon request to the authorized individual or agency involved in the medical treatment. This provision will be invoked if the emergency contacts provided are unable to be reached.

_____ _____

CONSENT SIGNATURE (Volunteer/Parent/Guardian) Date

❒ **NON-CONSENT PLAN** – I do not give my consent for emergency medical treatment/aid in the case of illness or injury while performing volunteer duties on behalf of Hope Therapy, Inc. In the event emergency aid or treatment is required for my care, I wish the following procedures to take place._____

_____

_____ _____

NON-CONSENT SIGNATURE (Volunteer/Parent or Guardian) Date

Criminal History:

Have you ever been convicted of a crime? ❒ Yes ❒ No

If "Yes" please explain_____

_____

I _____(printed name of volunteer) authorize Hope Therapy, 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, including, but not limited to convictions for crimes committed upon children or animals. I understand that such access is to consider my application as a volunteer. I expressly DO NOT authorize Hope Therapy, 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 (Volunteer/Parent or Guardian) Date

Liability Release:

I _____ (printed name of volunteer) would like to participate in the Hope Therapy, Inc. Hippotherapy Program. I acknowledge the risks and potential for risks of working around horses. However, I feel that the possible benefits to me/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 for damages against Hope Therapy, Inc: its Board of Directors, Instructors, Therapists, Aids, Volunteers and/or Employees for any and all injuries and/or loses I/my son/my daughter/ my ward may sustain while participating in the Hope Therapy, Inc. Hippotherapy Program.

_____ _____

SIGNATURE (Volunteer/Parent or Guardian) Date

Photo Release:

I _____ (printed name of volunteer) hereby consent to and authorize the use of reproduction by Hope Therapy, Inc. of any and all photographs and any other media materials taken of me/my son/ my daughter/my ward for promotional printed material, social media, educational activities of any other use for the benefit of the program.

_____ _____

SIGNATURE (Volunteer/Parent or Guardian) Date

Covid Waiver:

In consideration of being allowed to participate in any way in any activity sponsored at or by Hope Therapy, Inc. I, the undersigned volunteer, parent, or legal guardian, acknowledge, understand, and agree that by participating in these activities: (1) there are certain risks to me and/or my child(ren) arising from or related to possible exposure to communicable diseases including, but not limited to, COVID-19, the virus "severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2)", which is responsible for the Coronavirus Disease (also known as COVID-19) and/or any mutation or variation thereof (collectively referred to as "Communicable Diseases"); (2) I am fully aware of the hazards associated with such Communicable Diseases and; (3) I knowingly and voluntarily assume full responsibility for any and all risk of personal injury or other loss that I may sustain in connection with such Communicable Diseases, and: (4) I, for myself or for my minor child(ren) or ward(s), and on behalf of my/our heirs, assigns, beneficiaries, executors, administrators, personal representatives, and next of kin, HEREBY EXPRESSLY RELEASE, HOLD HARMLESS, AND FOREVER DISCHARGE HOPE THERAPY, INC and its officers, officials, agents, representatives, employees, other participants, sponsors, advertisers, and, if applicable, owners and lessors of premises upon which Hope Therapy related events and activities take place (the "Released Parties"), from any and all claims, demands, suits, causes of action, losses, and liability of any kind whatsoever, whether in law or equity, arising out of or related to any ILLNESS,

INJURY, DISABILITY, DEATH, OR OTHER DAMAGES incurred due to or in connection with any Communicable Diseases, WHETHER ARISING FROM THE NEGLIGENCE OF THE RELEASED PARTIES OR

OTHERWISE, to the fullest extent permitted by law. I agree that this Agreement is intended to be as broad and inclusive as is permitted by the laws of the State of Florida, and if any portion hereof is held invalid, it is agreed that the remainder shall continue in full legal force and effect.

I HAVE READ THIS COVID RELEASE OF LIABILITY AND ASSUMPTION OF RISK AGREEMENT, FULLY UNDERSTAND ITS TERMS, UNDERSTAND THAT I HAVE GIVEN UP SUBSTANTIAL RIGHTS BY SIGNING IT, AND SIGN IT FREELY AND VOLUNTARILY WITHOUT ANY INDUCEMENT.

_____ _____

SIGNATURE (Volunteer/Parent or Guardian) Date

Confidentiality Agreement:

The purpose of this Confidentiality Agreement is to protect the identity and privacy of our cliens. Staff and Volunteers at Hope Therapy, Inc. encounter personal and sensitive information about clients. This is particularly true when assisting clients with sensitive medical histories, clients who are victims of abuse/neglect, or those involved in custody disputes. Therefore, it is very important to refrain from disclsing any information to third parties about our clients to avoid causing them harm. Confidential client information should never be discussed in the presence of third parties, except under the terms outlined below. Any files and/or documents containing confidential informationshould never be shared or released to third parties, except under the terms outlined below. Confidential information includes, but is not limited to the following:

1. Identifying information about the client, including name, address or phone number.
2. Information relating to the client's family.
3. Information about abuse, trauma and/or persecution experienced by the client.
4. Any other information that would identify the client or potentially place the client and/or family members at risk.

By signing this Confidentiality Agreement, you agree to the highest ethical standards and to abide by the following provisions:

1. All communication between Hope Therapy staff, volunteers and clients are confidential.
2. The staff or volunteer shall not disclose confidential information to a third party without the client's express consent to release such information.
3. The staff or volunteer shall not disclose confidential information to a third party without Hope Therapy, Inc. knowledge and consent.

4. I understand that as a volunteer, I have a duty to keep client information confidential throughout my term as a volunteer as well as after my volunteer status ends.
5. I understand that my failure to abide by the termsof this Confidentiality Agreement may result in the termination of my participation as a volunteer at Hope Therapy, Inc.

I_____(printed name of volunteer) have read the above Hope Therapy, Inc Confidentialty Agreement and understand its terms and my responsibility as a volunteer.

_____ _____

SIGNATURE (Volunteer/Parent or Guardian) Date