Therapeutic Riding Of Tryon
The Therapeutic Riding Program at FENCE

3381 Hunting Country Road
Tryon, NC 28782
Phone: 828-859-9021
Fax: 828-859-9315
Email: therapeuticriding@fence.org

VOLUNTEER ANNUAL UPDATE FORM

NAME: _____

HOME ADDRESS: _____

CITY/STATE/ZIP: _____

HOME PHONE: ( ) _____ - _____ CELL PHONE: ( ) _____ - _____

E-MAIL: _____

EMPLOYER/SCHOOL: _____

WORK ADDRESS: _____

_____ WORK PHONE: ( ) _____ - _____

Parent/Legal Guardian Name and Address if different from above: _____

_____

_____

LIABILITY RELEASE

I understand that involvement in "equine activity", as defined by applicable laws, involves inherent risks associated with the dangers and conditions which are an integral part of equine activities. These risks include, but are not limited to, the propensity of equines to behave in ways which may result in injury, harm, or even death to humans or other animals around or near them; the unpredictability of equine reaction to sounds, sudden movements, smells, and unfamiliar objects, persons or other animals; hazards related to surface or subsurface conditions; collisions with other equines or objects; and the potential of a participant to act in a negligent or unskilled manner which may contribute to injury to the participant or others, including the failure or inability to maintain control over the animal.

By participating in this activity, I agree to assume responsibility for these risks and I release and agree to hold harmless Therapeutic Riding of Tryon, the Foothills Equestrian Nature Center (FENCE), their officers, agents, employees and all volunteers assisting in the conduct of this activity, from all liability for negligence resulting in accidents, damage, injury or illness to myself and my property.

_____ _____

Signature (parent or legal guardian sign if minor) Date

Please ensure that you complete and sign all sections of this form and then return it to:
TROT, 3381 Hunting Country Road, Tryon NC 28782.

Revised June 2013

STATEMENT AND AGREEMENT ON CONFIDENTIALITY

During your activities related to Therapeutic Riding of Tryon, you may be exposed to a client's confidential information. It is the legal and ethical responsibility of all TROT staff and volunteers to preserve and protect the privacy rights of our clients. Laws controlling the privacy of, access to and maintenance of confidential information include, but are not limited to, the federal Health Insurance Portability and Accountability Act (HIPAA) and the relevant laws of the state of North Carolina. These and other laws apply whether the information is held in electronic or any other form, and whether the information is used or disclosed orally or in writing.

Confidential information includes information that identifies or describes an individual and the disclosure of which would constitute an unwarranted invasion of personal privacy. Examples of confidential client information include home address and telephone number, medical information (described in the next paragraph), birth date, citizenship, social security number, spouse/partner/relative's name(s), and evaluations, whether in written form or stored electronically, related to activities the client performs in connection with TROT.

Medical information includes the following: medical and psychiatric records, including paper printouts, photos, videotapes, diagnostic and therapeutic reports, x-rays, scans, laboratory and pathology reports; client business information, such as bills for service or insurance information; electronically stored or transmitted patient information; verbal information provided by or about a client; instructor or physician evaluation forms, whether in written or electronic form; or other information the disclosure of which would constitute an unwarranted invasion of privacy.

Acknowledgement of your responsibility

I understand and acknowledge that:

It is my legal and ethical responsibility to preserve and protect the privacy, confidentiality and security of all records and other confidential information relating to TROT, its clients, activities and affiliates, in accordance with applicable law.

I agree to discuss confidential information only in the context of my duties and activities for TROT. I will not knowingly discuss any confidential information within the hearing of other persons who do not have the right to receive that information. I agree to protect the confidentiality of any medical or other confidential information which incidentally disclosed to me in the course of my duties and activities with TROT.

I understand that psychiatric records, drug abuse records, and any and all references to HIV testing used to identify HIV or a component of HIV, are especially protected by law.

I understand that any violation of any of the procedures and policies of TROT or the Foothills Equestrian Nature Center, Inc., related to confidential information, or of any state or federal laws or regulation governing a client's right to privacy, may subject me to legal and/or disciplinary action up to and including immediate termination of my relationship with, and activities for, TROT.

I understand that I may be criminally liable for harm resulting from my breach of this Agreement and that I may also be held criminally liable under the HIPAA privacy regulations for an intentional and/or malicious release of protected health information.

_____ _____

Signature (parent or legal guardian sign if minor) Date

Revised February 2016

HEALTH HISTORY

VOLUNTEER NAME: _____

Do you have: a current tetanus shot? _____ a recent tuberculosis test? _____
(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 a therapeutic riding program. Address fitness, cardiac, respiratory, bone or joint function, recent hospitalization/surgeries, or lifestyle changes.

_____

_____

Allergies: _____

Medications: _____

Emergency Contact: _____

In the event that emergency medical treatment is required due to illness or injury while performing my duties as a TROT volunteer (check one):

_____ I authorize the Foothills Equestrian Nature Center, Inc., to secure and retain medical treatment and transportation if needed and release my medical records on request to the authorized individual or agency involved in the medical emergency treatment. This authorization includes x-ray, surgery, hospitalization, medication and any treatment deemed "life saving" by the attending physician.

____ I DO NOT authorize the Foothills Equestrian Nature Center, Inc. to secure and retain medical treatment and transportation if needed, or to release my medical records on request to the authorized individual or agency involved in the emergency medical treatment. In the event such emergency treatment is required, I wish the following action to be taken:

_____

I certify that I am in general good health, that I am capable of the physical requirements of volunteering for TROT and that I know of no reason why I should not participate in the program as a volunteer.

_____ _____
Signature (parent or legal guardian sign if minor) Date

PHOTO RELEASE

____ I DO / ____ I DO NOT consent to and authorize the use and reproduction by the Foothills Equestrian Nature Center of any and all photographs and any other audio/visual materials taken of me for promotional material, educational activities, exhibitions, social media or for any other use for the benefit of the program.

_____ _____
Signature (parent or legal guardian sign if minor) Date