



**BACKGROUND VERIFICATION:**

1. Have you ever been convicted of a criminal offense?  YES  NO

2. Have you ever been charged with neglect, abuse or assault?  YES  NO

Please Explain: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

3. Please list 2 non-family references whom we might contact:

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

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

**LIABILITY STATEMENT:** I will not hold TROT liable for any accident or injury incurred while participating in the TROT sessions or related activities nor will TROT, its staff, Board of Directors, owners of the horses or owners of the premises be liable for same. \_\_\_\_\_ (INITIAL)

**PHOTO/VIDEO RELEASE:** I hereby grant Therapeutic Riding of Tucson, Inc. permission to use any and all photographs, slides and any other audiovisual materials in which I may appear for the express purpose of promoting the TROT program and do not expect, nor shall receive any monetary reimbursement for this authorization. \_\_\_\_\_ (CONSENT--Initial) \_\_\_\_\_ (NON-CONSENT- Initial)

**PHYSICAL REQUIREMENTS:** I realize that many of the volunteer jobs at TROT require me to be in good health, physically active and mentally alert and focused for the two to three hour session. I also acknowledge that I must be able to walk briskly, occasionally trot, and also be able to tolerate times when there may be severe weather and dust. \_\_\_\_\_ (INITIAL)

I, \_\_\_\_\_, have read and understand the contents of this document. The information provided by me is complete, true and accurate to the best of my knowledge.

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

IF MINOR, Signature of Parent/Guardian \_\_\_\_\_

**Good Faith Agreement: Consistency and commitment to our special needs riders is an important aspect of TROT volunteer service. By accepting a permanent position as a side walker and/or horse handler for a least one twelve week semester, I agree to honor this commitment of 1.5 hours per week for the entire semester.**

**Signature \_\_\_\_\_ Date \_\_\_\_\_**

**IF MINOR, Signature of Parent/guardian \_\_\_\_\_**

# MEDICAL HISTORY & EMERGENCY TREATMENT RELEASE INFORMATION

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_

## MEDICAL INFORMATION:

Physician: \_\_\_\_\_

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

Medical Insurance Company: \_\_\_\_\_

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

Policy Number: \_\_\_\_\_ group # \_\_\_\_\_

Company or Agent Phone: \_\_\_\_\_

## IN CASE OF EMERGENCY:

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

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

## HOSPITAL PREFERENCE:

You will be taken to TMC or ST. Joseph's Hospital unless you designate a preference below:

I PREFER TO BE TAKEN TO: \_\_\_\_\_ HOSPITAL.

*In case of emergency, I give permission to Therapeutic Riding of Tucson to secure medical treatment including x-ray, surgery, hospitalization and medication . \_\_\_\_\_ (INITIAL)*

## MEDICAL HISTORY:

Medications: \_\_\_\_\_

Allergies: (medications, insect bites etc.) \_\_\_\_\_

Pertinent Medical Conditions: \_\_\_\_\_

Useful Medical History: \_\_\_\_\_

I deem the above information to be true and correct: Signature: \_\_\_\_\_

IF MINOR Signature of Parent/Guardian \_\_\_\_\_

# TROT POLICY OF CONFIDENTIALITY

## DISCLOSURE OF MEDICAL AND/OR SENSITIVE INFORMATION

General Principles: Therapeutic Riding of Tucson shall preserve the right of confidentiality for all individuals who participate in its program.

Procedure: All medical, social, referral, personal, and financial information regarding a person and his/her family shall be kept confidential.

Anyone who works or volunteers for, or provides services to Therapeutic Riding of Tucson, shall be bound by this policy. This policy includes but is not limited to full and part-time staff, volunteers, independent contractors, temporary employees and board members.

Disclosure of information to outside agencies or individuals shall be done only with the specific written consent of the student. If a student is under the age of eighteen (18) and/or not competent to give consent for disclosure, then a parent or legal representative must give informed consent. Intra-agency disclosure of medical and/or sensitive information shall be on an as needed basis only. **Disclosure of Specific information regarding a participant's disability is at the sole discretion of the NARHA Certified Instructor and requires signed permission of the participant, parent, or guardian.**

The Program Director and Director of Volunteer Services shall ensure that all staff, volunteers, and board members receive a copy of the confidentiality policy. All Staff, volunteers and board members shall sign the confidentiality statement below that pledges to protect the confidentiality of all information regarding individuals who participate in the TROT program.

Penalties: Violations of this policy which result in a breach of confidentiality may result in reprimand, loss of certain job responsibilities or termination. The Program Director shall be responsible for reviewing any violation of this policy.

### CONFIDENTIALITY STATEMENT

**I have read and understand the above policy of confidentiality for Therapeutic Riding of Tucson. A copy of this policy has been made available to me. I agree to observe and follow all of the procedures contained therein.**

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

**IF MINOR, Signature of Parent/Guardian \_\_\_\_\_**