



Bridge Riding for the Disabled  
743 West Pekin Road  
Lebanon, Ohio 45036-8492  
1-937-654-4693



### VOLUNTEER FORM

(one per volunteer)

Name \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Work phone \_\_\_\_\_ email \_\_\_\_\_

Are you available days? \_\_\_\_\_ Evenings? \_\_\_\_\_ Weekends? \_\_\_\_\_

Do you have any physical limitations? Y/N Specify \_\_\_\_\_

Can you walk for 60 minutes and jog for short distances? Y/N \_\_\_\_\_

Given a chance to change sides frequently, can you hold your arm above shoulder height and support a modest weight? Y/N \_\_\_\_\_

Are you comfortable working or walking around horses/ponies? Y/N \_\_\_\_\_

Do you have experience with horses or ponies? Y/N Specify \_\_\_\_\_

Do you have any other skills or training which may be of benefit to our program? \_\_\_\_\_

Where did you first hear about Bridge Riding for the Disabled? \_\_\_\_\_

Background Information: Have you ever been charged with or convicted of a crime? Y/N \_\_\_\_\_

If yes please explain.

I, \_\_\_\_\_ authorize Bridge Riding for the Disabled to receive information from any law enforcement agency 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. I DO NOT authorize Bridge Riding to disseminate this Information in any way to any other individual, group, agency, organization, or corporation.

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

Current Driver's License Y N License Number \_\_\_\_\_ State \_\_\_\_\_

**BRIDGE RIDING FOR THE DISABLED (937) 654-4693  
AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT**

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 Bridge Riding for the Disabled to:

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

Treatment for whom: \_\_\_\_\_ Phone:(\_\_\_\_\_)\_\_\_\_\_

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

City: \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Contact: \_\_\_\_\_ Phone:(\_\_\_\_\_)\_\_\_\_\_

Contact: \_\_\_\_\_ Phone:(\_\_\_\_\_)\_\_\_\_\_

Physician's Name: \_\_\_\_\_ Phone:(\_\_\_\_\_)\_\_\_\_\_

Preferred Medical Facility: \_\_\_\_\_

Health Insurance Co.: \_\_\_\_\_ Policy#:\_\_\_\_\_

**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 listed below is unable to be reached.

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

(Client, Parent or Guardian)

Print Name:\_\_\_\_\_ Phone:(\_\_\_\_\_)\_\_\_\_\_

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

**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

Date:\_\_\_\_\_ Non-consent Signature:\_\_\_\_\_

Photo Release:

I consent to and authorize the use and reproduction by Bridge Riding for the Disabled of any and all photographs and any other audio-visual materials taken of me for promotional material, educational activities, exhibitions or for any other use for the benefit of the program.

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