



## Health History

**Diagnosis / Conditions:** \_\_\_\_\_

Please explain your current health status, specifically regarding the physical and emotional demands of working in a therapeutic recreation program. Address fitness, cardiac, respiratory, bone or joint functions, recent hospitalizations or surgeries, cognitive abilities, and mental and emotional stability.

---



---

**Allergies:** \_\_\_\_\_

---

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

---

### Interests:

Winslow needs volunteers in a variety of capacities. Please check the box in areas in which you are skilled and willing to share your gifts or willing to learn.

<b>Programming</b>	Experienced	Somewhat Experienced	Willing to Learn
Grooming Horses			
Tacking Horses			
Horse Handling			
Leading Horses in Lessons			
Sidewalking in Lessons			
Arts & Crafts			
<b>Administrative</b>			
Fundraising			
Marketing/PR			
Photography			
Newsletter			
Data Entry			
Non-Profit Sector			
Event Planning			
<b>Facilities &amp; Maintenance</b>			
Trail Repair & Maintenance			
Gardening/Mowing/Weed-whacking			
Mucking Stalls			
Facility Repair & Maintenance			
Excavation			

**Please answer the following questions:**

Please indicate any past or current participation in a Winslow program:

- Therapeutic Lessons                       Traditional Lessons                       Summer Adventures  
 Summer Youth Leadership Academy                       Day at the Barn                       Visiting Classroom (school group)  
 I have never participated in Winslow's programs

I am able to stand for at least 2 hours and walk for at least 30 minutes at one time.    Yes     No

I am able to jog lightly for 30 seconds at a time, and approximately 5 minutes total within a 30-minute period?  
 Yes     No

I will be able to perform various barn chores WITHOUT the assistance of others including but not limited to: cleaning stalls, sweeping, sanitizing, and cleaning tack.    Yes     No

Volunteers MUST be independent in all functions, not require the assistance of others to engage in any activities and have intact safety and environment awareness. Do you require assistance in performing heavy work or being aware of your surroundings?    Yes     No

Do you have experience with horses? If yes, please briefly explain.

---

---

Do you have experience working with disabled children or adults? If yes, please briefly describe.

---

---

Do you have previous volunteer experience?

---

---

Why did you choose Winslow for volunteering?

---

---

What do you hope to gain from volunteering at Winslow?

---

---

**Liability Release:**

\_\_\_\_\_ **(Volunteer's Name)** would like to participate as a volunteer at Winslow Therapeutic Center. I acknowledge the risks of working with horses, and horseback riding. However, I feel that the possible benefits to myself are greater than the risks assumed. I hereby (for myself, my heirs and assigns, executors, or administrators) waive and release forever all claims for damages against Winslow Therapeutic Riding Unlimited, Inc., Winslow Therapeutic Center, its Board of Directors, Instructors, Therapists, Aides, Volunteers, and/or employees, for any and all injuries and losses I may sustain while participating in Winslow programs or events

Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Volunteer/Parent/Guardian Name: \_\_\_\_\_  
(mm/dd/yyyy)  
Volunteer/Parent/Guardian Signature: \_\_\_\_\_

**Photo and Video Recording Policy:**

Winslow's confidentiality policy and photo release policy extend to participants, volunteers, animals, and staff. Prior to taking a photo or video recording your participant, you must ask the instructor to ensure that all individuals present have a photo release. There is also NO flash photography as this could startle the animals. \_\_\_\_ **Initial**

**Confidentiality Agreement:**

I agree to respect and observe privacy and confidentiality of the participants, volunteers, horses and personnel of Winslow Therapeutic Riding Center and not to discuss or disclose any sensitive information about any horse, person or their family.

Volunteer's Name: \_\_\_\_\_

Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Volunteer/Parent/Guardian Signature: \_\_\_\_\_  
(mm/dd/yyyy)

**Photo Release:**

I hereby consent to and authorize the use and reproduction by Winslow of any and all photographs and any other materiel, educational activities, exhibitions or for any other use the benefit of the program.

Consent    Do Not Consent

Volunteer's Name: \_\_\_\_\_

Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Volunteer/Parent/Guardian Signature: \_\_\_\_\_  
(m/dd/yyyy)

**Have you served in the Military:**    YES                       NO (go to next page)

**If you answered YES, are you:**                       Currently Serving                       A Veteran                       On Leave

**What branch of the Military are/were you enlisted?** \_\_\_\_\_

## 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 Winslow Therapeutic Riding Unlimited, Inc. to:

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

Volunteer's Name: \_\_\_\_\_

Volunteer's Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_ Zip: \_\_\_\_\_

Legal Guardian Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Legal Guardian Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

### Emergency Contacts (do not list legal guardians):

Emergency Contact Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Primary Care Provider's Name: \_\_\_\_\_

Primary Care Provider's Facility: \_\_\_\_\_

Primary Care Provider's Phone Number: \_\_\_\_\_

Preferred medical facility for treatment: \_\_\_\_\_

Health Insurance Company: \_\_\_\_\_ Policy # \_\_\_\_\_ Group # \_\_\_\_\_

### Consent for Treatment Plan:

Consent     Do Not Consent

This authorization is for \_\_\_\_\_ (Volunteer's Name) and 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 below is unable to be reached.

Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Volunteer/Parent/Guardian Name: \_\_\_\_\_  
(mm/dd/yyyy)

Volunteer/Parent/Guardian Signature for Consent for Treatment: \_\_\_\_\_



# Participation Income Survey

**Orange County Community Development Office Requirement:**

Winslow Therapeutic Riding Center is required by the Orange County Community Development Office (OCCD) to track the income range of all participants in order **to continue receiving funding which subsidizes ALL lesson costs. Using this form, in Section 1 please circle the applicable income limit listed under your household size.** Section II of the form is voluntary. Winslow is committed to keeping the confidentiality of all client information and submits it anonymously. As you **UPDATE** the participant's application, please be assured that **all data is held in strictest confidence.** Thank you for helping Winslow qualify for funding that benefits all of our clients.

**SECTION I**

Town/City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ County: \_\_\_\_\_

# of people in your household enrolled in Winslow's programs (not volunteering): \_\_\_\_\_ Start Year: \_\_\_\_\_

Using the chart below, please **CIRCLE** your income level based on the number of individuals in your household.

Number in household	1 person	2 persons	3 persons	4 persons	5 persons	6 persons	7 persons	8 persons
(1) Equal to or less than	\$33,150	\$37,850	\$42,600	\$47,300	\$51,100	\$54,900	\$58,700	\$55,050
(2) Equal to or less than	\$50,350	\$57,550	\$64,750	\$71,900	\$77,700	\$83,450	\$89,200	\$94,050
(3) Greater than	\$50,350	\$57,550	\$64,750	\$71,900	\$77,700	\$83,450	\$89,200	\$94,050

**SECTION II**

How many families currently reside at the address listed above? \_\_\_\_\_

If more than one family, please have each family complete this questionnaire. Please copy the questionnaire or request a blank copy from Winslow.

Do you or anyone in the household receive rental income from the property listed above or any other owned?  Yes  No

Residency:  Own  Rent

**Ethnic Group - please indicate the choice that pertains to the participant**

Hispanic or Latino  Non-Hispanic or Latino

**Racial Group - please indicate the choice that pertains to the participant**

- White  Black/African American  American Indian/Alaska Native
- Asia  Black/African American & White  American Indian/Alaska Native & White
- Asian & White  Native Hawaiian/Other Pacific Islander  American Indian/Alaska Native & Black/African
- Multi Racial  American

Do you or anyone in the household receive alimony/child support?  Yes  No

# of people in your family over the age of 62 years old: \_\_\_\_\_

Are any family members disabled?  Yes  No If yes, please indicate how many: \_\_\_\_\_