



KaleidoScope

KaleidoScope Therapeutic Riding Program
21 Branin Road
Medford, NJ 08055
609-923-7847

Volunteer/Staff Information Form and Health History

General Information

Name: _____ Date: _____

Address: _____

Date of Birth: _____ Phone: (H) _____ (W) _____

Employer/School: _____

Address: _____

Parent/Legal Guardian/Caregiver Name/Address/Phone Number: _____

How did you learn about the program? _____

Recent medical tests: _____ Last Tetanus Shot: _____ Tuberculosis Test + — Date: _____

(Consult your physician or local health department if you are not up to date with these shots/tests)

Health History

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

Allergies:

Medications:

Check areas in which you are interested:

Program Special Events Administration

Horse Handling Horse Show Public Relations Photography/Video

Sidewalking With a Student Fundraising Grant Writing Budget & Finance

Stable Management Special Olympics Newsletter Future Planning

Facility Repairs Trail Rides Volunteer Recruitment

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 in this center's program.

Signature: _____ Date: _____

(volunteer/staff/caregiver; signed in presence of center staff)

KaleidoScope Office Mailing Address:
23 Elmwood Drive, Tabernacle, NJ 08088
E-Mail: KaleidoScopeTR@yahoo.com

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Name: _____

Address: _____

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Photo Release

I

DO

DO NOT

consent to and authorize the use and reproduction by ***KaleidoScope Therapeutic Riding Program, Inc.*** 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.

Signature: _____ Date: _____

Background Information

Have you ever been charged with or convicted of a crime? Y N Please explain _____

I, _____ (volunteer/staff), authorize ***KaleidoScope Therapeutic Riding Program, 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, 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 or animals. I understand that such access is for the purpose of considering my application as an employee/volunteer, and I expressly DO NOT authorize the PATH Intl. Center, its directors, officers, employees or other volunteers to disseminate this information in any way to any other individual, group, agency, organization or corporation.

Signature: _____ Date: _____

(volunteer/staff)

CURRENT DRIVER'S LICENSE Y N LICENSE NUMBER _____ STATE _____

Confidentiality Agreement

I understand that all information (written and verbal) about participants at this PATH Intl. Center is confidential and will not be shared with anyone without the expressed written consent of the participant and his/her parent/guardian in the case of a minor.

Signature: _____ Date: _____

(volunteer/staff)