



“Using Humans and Horses to
Help Disabilities Become Abilities”

Volunteer Application

Thank you for your interest in volunteering with us! Please complete the following form. It is important to fill out the entire form and not leave anything blank. Thank you!

Please note: Steps To Your Dreams cannot accept any applicants, who have been arrested for, or convicted of, crimes against persons and/or animals.

Name: _____ Date: _____
Address: _____ City: _____ Zip _____
Home Phone: () _____ Cell Phone: () _____
Email: _____ Preferred Contact Method _____
Occupation: _____ Employer: _____
If Student, School: _____ Grade Level: _____
Parent/Guardian name and address if under 18: _____

Junior Volunteer Requirements

(Between the ages of 14 and 18)

- Must be at least 14 years of age
- Must be accompanied by a parent, adult family member, or guardian
- Demonstrate the ability to act responsibly in the barn area and follow barn rules and guidelines
- Not able to participate directly in therapy session
- Attend a New Volunteer Orientation and appropriate training
- All volunteers under the age of 14 must be under direct supervision **at all times.**

I agree to provide adult supervision as stated in the Junior Volunteer Requirements above.

Parent/Guardian Signature: _____
(Signature of parent/guardian if volunteer is under 14 years of age)



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Please check which volunteer areas *most* interest you:

Equine Care:

- Barn Help
- Feeding
- Grooming
- Side Walker
- Training

Administration:

- Office Help
- Newsletter
- Website

Special Events:

- Fundraising
- 5K Run/Walk
- Dream Ride

Other: _____
(Please list skills you would like to offer our program)

Why are you interested in volunteering with us? _____

How many hours per week? _____

What day(s) and time(s) are preferred? _____

Are you comfortable around horses? Yes No

Do you have previous experience training or working with horses? Yes No
If yes, please describe:

Do you have experience or training working with individuals with disabilities? Yes No
If yes, please describe:

Are you able to walk for 30 minutes? Yes No

Do you have health issues or physical limitations that we should be aware of? Yes No
If yes, please describe:

I accept full responsibility to inform those I am working with of my limitations.

Volunteer Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

(Signature of volunteer if under 18 years of age)



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Volunteer Liability Release

I, _____ (Volunteers Name) would like to participate in Steps To Your Dreams Hippotherapy program. I acknowledge the risks and potential for risks of participating in a horseback riding program and horse related activities. I understand that my participation is voluntary and release Steps To Your Dreams, Therapists, Board of Directors, Volunteers, Equine, Equine Owners, and Equipment of all liability or blame for any injury, accident, harm, loss, or inconvenience or damage suffered or sustained by participating in Steps To Your Dreams Hippotherapy program. I am aware that a horse can behave in ways that may be harmful to persons on or around the horse due to unpredictability of a horse’s reaction to sounds, sudden movements, unfamiliar objects, persons, or other animals.

Volunteer Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____
(Signature of volunteer if under 18 years of age)

Volunteer Photo Release

(Please only sign one option, not both)

I hereby consent to and authorize the use and reproduction of Steps To Your Dreams Foundation, Inc. of any and all photographs, audio tapes, and/or videotapes taken for promotional material, educational activities, website, or for any other use for the benefit if the program. I understand that I may withdraw consent for any further photographs or taping but that photos or tapes already in existence may continue to be in circulation for an indefinite period of time.

____ Photo Release Signature: _____ Date: _____
(Signature of parent/guardian if volunteer is under 18)

____ Do not Photograph Signature: _____ Date: _____
(Signature of parent/guardian if volunteer is under 18)



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Volunteer Authorization for Emergency Medical Treatment

Physicians Name: _____ Phone: () _____

Preferred Medical Facility: _____

Health Insurance Company: _____ Policy #: _____

Allergies to medication: _____

Current medication: _____

Person(s) to be contacted in case of an emergency:

Name: _____ Relations: _____ Phone: () _____

Name: _____ Relations: _____ Phone: () _____

Name: _____ Relations: _____ Phone: () _____

Consent for emergency medical treatment is required of all our volunteers due to the risk of injury when participating in horse related activities.

In the event emergency medical treatment/aid is required due to illness or injury during my participation at Steps To Your Dreams, or while on the property, I authorize Steps To Your Dreams Foundation Inc. to:

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

Please check one:

 Consent Plan:

This authorization includes x-ray, surgery, hospitalization, medication, and any other treatment procedure deemed “life saving” by the physician. This provision will only be invoked if the above person(s) is unable to be reached.

 Non-Consent Plan:

I do not give my consent for emergency medical treatment/aid in case of illness or injury during my participation at Steps To Your Dreams, or while on the property.

Signature: _____ Date: _____

(Signature of parent/guardian if volunteer is under 18)

In the event emergency treatment/aid is required, I wish the following procedures to take place:



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Volunteer Confidentiality Policy

“What happens at Steps To Your Dreams, stays at Steps To Your Dreams”

Steps To Your Dreams Foundation recognizes the right of our patients and their families to have privacy and control over any information that may be personal and preferred to be kept within our facility. In order for us to respect that right, we require our volunteers to keep all information regarding our patients and their families confidential regardless of how that information is obtained. Confidential information consists of anything related to their medical history, family, social, referral, personal, and financial concerns. The therapists may feel it is necessary to release medical or behavioral information for volunteers participating directly with the patient. Any person violating these policies will be subject to the appropriate penalties.

I have read and understand the Volunteer Confidentiality Policy as described above and agree to follow these guidelines.

Signature: _____

(Signature of parent/guardian if volunteer is under 18)

Date: _____