

Wings of Eagles Ranch

Therapeutic Horseback Riding Center
Serving Cabarrus County and surrounding areas since 1999

Volunteer Application

Application Date: ___/___/___

I am interested in volunteering for:

Fall Winter Spring Summer Camps Field trips (Fridays) Work days Fundraising

My available times are:

Tue 3pm 4pm 5pm 6pm Wed 10am 11am 12pm Thu 3pm 4pm 5pm



Have you attended a volunteer training session? Yes No Date attended training: ___/___/___

How did you learn about the program? _____

Last name: _____ First name: _____

Street address: _____

City, State and Zip: _____

Primary phone: _____ Male Female Date of birth: ___/___/___ Height: _____

Primary email: _____

If applicant is under 18 years old, please provide the following:

Parent / Guardian name: _____

Parent / Guardian primary phone: _____

Photo Release

I DO DO NOT consent to and authorize the use and reproduction by Wings of Eagles Ranch of any and all photographs and any other audio/visual materials taken of me for promotional material, educational activities, and exhibitions or for any other use for the benefit of the program.

The information provided above is accurate to the best of my knowledge. I know of no reason why I should not participate in the Wings of Eagles Ranch Therapeutic Horseback Riding and Outdoor Adventures program.

Applicant signature: _____ Date: ___/___/___

If applicant is under 18 years old, please provide the following:

Parent / Guardian signature: _____ Date: ___/___/___

Background Check

Application Date: ____ / ____ / ____

Last name: _____ First name: _____

References – Must be non-family and over the age of 25.

Reference #1 (Name, phone): _____

Reference #2 (Name, phone): _____

Reference #3 (Name, phone): _____

Most recent Employer School Advisor (Name, phone): _____

Criminal History (over 18 years)

Have you ever been convicted of a crime other than a traffic violation? Yes No

If yes, please describe: _____

Have you ever been convicted of any crime against a child or any form of child abuse? Yes No

If yes, please describe: _____

I hereby authorize Wings of Eagles Ranch to contact any references listed herein to verify all information provided and to obtain any and all information related to my character and past work performance. I further hereby release all references from any liability of information provided in good faith.

The information provided above is accurate to the best of my knowledge. I know of no reason why I should not participate in the Wings of Eagles Ranch Therapeutic Horseback Riding and Outdoor Adventures program.

Applicant signature: _____ Date: ____ / ____ / ____

If applicant is under 18 years old, please provide the following:

Parent / Guardian signature: _____ Date: ____ / ____ / ____

Relevant Experience

Wings of Eagles Ranch or other Camp Experience: _____

Certifications/Experience

- | | | |
|--|---|---|
| <input type="checkbox"/> Low Ropes Courses | <input type="checkbox"/> High Ropes Courses | <input type="checkbox"/> Lifeguard |
| <input type="checkbox"/> CPR | <input type="checkbox"/> NARHA | <input type="checkbox"/> Certified Horsemanship Association |
| <input type="checkbox"/> Certified Nursing Assistant | <input type="checkbox"/> Registered Nurse | <input type="checkbox"/> EMT |

Horses

Do you ride? Yes No

Discipline: Western or English

Frequency: Weekly Monthly Yearly

Do you own a horse? Yes No

Facility where you take lessons: _____ Trainer: _____

Interests – Check all that apply.

- | | | |
|--|--|---|
| <input type="checkbox"/> Horse Leader | <input type="checkbox"/> Public Relations | <input type="checkbox"/> Photography/Video |
| <input type="checkbox"/> Side Walker (14 yrs. & up) | <input type="checkbox"/> Fundraising | <input type="checkbox"/> Budget & Finance |
| <input type="checkbox"/> Jr. Volunteer/Barn Help | <input type="checkbox"/> Volunteer Recruitment | <input type="checkbox"/> Future Planning – 5 yr. vision |
| <input type="checkbox"/> Facility Repairs | <input type="checkbox"/> Board of Directors | |
| <input type="checkbox"/> Barn/Horse Maintenance | <input type="checkbox"/> Office Helper | |
| <input type="checkbox"/> Certified Riding Instructor | | |

Hobbies – Describe what you do in your free time.

Authorization for Emergency Medical Treatment

Physician's Name: _____ Medical Facility: _____

Health Insurance Company: _____ Policy #: _____

Allergies to Medications: _____

Current Medications: _____

Date of Last Tetanus Shot: _____ Tuberculosis Test (+ -) : Date: _____
(Consult your Physician or local health department if you are not up to date with shots/tests)

Do you have an allergic reaction to bug bites or bee stings? Yes No

If stung by a bee, do you give us permission to administer liquid Benadryl? Yes No

Signature: _____

(If under 18, Parent or Legal Guardian)

In the event of an emergency, contact:

Emergency contact #1 (name, relation, and phone):

Emergency contact #2 (name, relation, and phone):

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 Wings of Eagles Ranch to: Secure and retain medical treatment and transportation if needed. Release client records upon request to the authorized individual or agency involved in the medical emergency treatment.

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(s) above is unable to be reached.

Date: ___/___/___ Consent Signature: _____

Client, Parent, or Legal Guardian

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

Date: ___/___/___ Signature: _____

Client, Parent, or Legal Guardian

