SPECIAL TROOPERS ADAPTIVE RIDING SCHOOL
33148 K22—Sioux City, IA 51108—www.scstars.org—P: 712.239.5042—F: 712.224.3471

Returning Volunteer Form

Name _____ Date of Birth _____ Height_____

Address _____City_____ State _____ Zip_____

Home Phone _____ Cell Phone _____

Email: _____ Other Languages_____

Best way to contact you: Home # ☐ Cell # ☐ E-Mail ☐ Text ☐

Best time of day to contact you: AM ☐ PM ☐ Weekends ☐ other _____

Parent/Guardian Name (if under 18) _____

Address (if different than above) _____

Availability:

- ☐ Monday daytime
- ☐ Tuesday daytime
- ☐ Wednesday daytime
- ☐ Thursday daytime
- ☐ Saturday daytime
- ☐ Monday evenings
- ☐ Tuesday evenings
- ☐ Wednesday evenings
- ☐ Thursday evenings
- ☐ willing to substitute. Please list days and times available: _____

I certify that the above information is correct to the best of my knowledge.

Signature _____ ***Date*** _____

Guardian Signature _____ ***Date*** _____
(If under 18 yrs., Parent/Guardian must sign)

THANK YOU FOR CONTINUING TO BE A STARS VOLUNTEER!

BACK PAGE

★ OUR MISSION: The purpose of STARS is to provide persons with disabilities with an animal-oriented therapeutic, rehabilitation and recreational program that will contribute to their physical and emotional health.

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Volunteer's Emergency Medical Information Form

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 STARS, Inc. to secure and retain medical treatment and transportation if needed.

Volunteer's Name _____ Phone _____

Address _____

Person to contact in case of emergency: Name _____

Relationship_____ Phone_____

Physician's Name _____ Phone_____

Preferred Medical Facility _____

Health Insurance Co _____ Policy # _____

Describe any medical condition requiring special precautions or treatment and any medications and dosage: (A**)** None _____ (B) Please describe _____
_____

Consent Plan

This authorization includes x-rays, surgery, hospitalization, medication and any other treatment procedure deemed "lifesaving' by the physician. This provision will only be invoked if the person listed above is unable to be reached.

➡ ***Consent Signature*** _____ ***Date*** _____
(Volunteer, if under 18, Parent/Guardian)
Print Name _____ ***Phone*** _____

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 rendering services or while being on the property of STARS, Inc.. In the event emergency treatment/aid is required, I wish the following procedures to take place:
_____
_____

Consent Signature _____ ***Date*** _____
(Volunteer, if under 18, Parent/Guardian)

Print Name _____ ***Phone*** _____

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