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

Please print legibly

NAME: ___________________________________ Age: ______ DOB: _____________ Height: _______

Address: _____________________________ City: _________________ State: ______ Zip: __________

Primary Phone: ______________________________ Secondary Phone: ___________________________

Email: ___________________________________ Best way to contact you: Email ☐ Phone ☐ or Text ☐

Parent/Guardian Name (if under 18): ________________________________ Phone: _____________________

Address (if different than above): ____

T-shirt Size: Youth ☐ ___________________ Adult ☐ ____________________

Do you know anyone else that would be interested in volunteering with our program? __________________________

Additional Information you would like to note: ____

____

VOLUNTEER PREFERENCES & INTERESTS

Availability: Please check all times you are available.

☐ Monday daytime
☐ Tuesday daytime
☐ Wednesday daytime
☐ Thursday daytime

☐ Monday evening
☐ Tuesday evening
☐ Wednesday evening
☐ Thursday evening

☐ Willing to substitute. Please list days and times available: ____________________________________

____

I would like to help in the following other areas. Please check all that apply!

☐ Special events
☐ Grounds maintenance
☐ Horse Camp
☐ Other Skills: ____

☐ Annual Spring fundraiser
☐ Photography/videos
☐ Annual horse show

Signature (Self, Parent, or Guardian): ____ Date: ____________

Printed Name: _________________________________ Relationship to Participant: ________________

***If under 18 years of age, Parent/Guardian MUST sign**

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AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

In the event emergency medical aid/treatment is required due to illness or injury while receiving services, being on property, or participating in an authorized activity of STARS, Inc., I authorize Special Troopers Adaptive Riding School (STARS, Inc.) to:

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

VOLUNTEER'S NAME: ____________________________________ Age: ________ DOB: _____________

Address: _____________________________ City: _________________ State: ______ Zip: __________

Primary Phone: ______________________________ Secondary Phone: ___________________________

Parent/Guardian Name (if under 18): ___________________________________ Phone: _______________________

In the event of an emergency, please list who should be contacted:

Contact Name: _____________________________ Relationship: _______________ Phone: _______________________

Contact Name: _____________________________ Relationship: _______________ Phone: _______________________

Physician's Name: ____

Preferred Medical Facility: ____

Health Insurance Company: ____ Policy #: ___________________________

CRITICAL HEALTH INFORMATION

(Ex: DNR, Food Allergies, Medication Allergies, etc.) ☐ None ☐ Yes - Please note below

____

____

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 below is unable to be reached.

Signature (Self, Parent, or Guardian): ____ Date: _____________

Printed Name: _________________________________ Relationship to Participant: ________________

If under 18 years of age, Parent/Guardian MUST sign

NON-CONSENT

*I do **NOT** give my consent for emergency medical treatment/aid in the case of illness or injury. Please note that by signing the non-consent this may exclude you from participating in programming at STARS Inc.*

Signature (Self, Parent, or Guardian): ____ Date: _____________

Printed Name: _________________________________ Relationship to Participant: ________________

If under 18 years of age, Parent/Guardian MUST sign