Rocking Horse Rehab
Horizon Pediatric Consultants, LLC
12-22 Woodland Ave.
West Orange, NJ 07052

Phone: 973-731-8588
Fax: 973-731-8520
www.rockinghorserehab.com

Dear Friend,

Thank you for inquiring about the volunteer opportunities we have within Rocking Horse Rehab (RHR), a pediatric rehab and family wellness center. Rocking Horse Rehab has been offering equine assisted therapy services since 1993. RHR is a comprehensive wellness center which offers speech, physical, and occupational therapy, hippotherapy, equine facilitated psychotherapy, therapeutic riding, music therapy, and therapeutic yoga. The clinic at Rocking Horse Rehab occupies approximately 2000 square feet of treatment rooms, offices, a kitchen, and a beautiful reception area with seven viewing windows overlooking our Olympic sized, heated, indoor arena.

The staff at Rocking Horse Rehab has been trained by the America Hippotherapy Association and/or the North America Riding for the Handicapped Association and specializes in treating impairments associated with medical conditions such as autism, cerebral palsy, sensory integration disorders, developmental delays, rare congenital disorders, brain tumors, traumatic brain injuries, and other neuromusculoskeletal disorders. The equine facilitated mental health programs are offered by a licensed clinical social worker who uses horses in therapy to treat psychiatric conditions such as ADHD, anxiety, depression, post-traumatic stress, mood disorders, and other social-emotional disorders.

The success of our programs is reliant upon the commitment of our generous volunteers. We would not be able to offer such innovative programs without them! We are hopeful that you will join our team of dedicated staff, equines, and volunteers!

Thank you,

Sheri A. Marino, MA, CCC-SLP

Executive Director

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Rocking Horse Rehab
© The Essex Equestrian Center

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We have many volunteer opportunities with our program. Please check off those that interest you and return this form along with the remainder of the registration materials to our address listed above. Once we receive your registration packet, we will call you to schedule an orientation.

Name: _____ Date: _____

___ Grooming Horses ___ Tacking Horses ___ Leading Horses

___ Spotting children during mounted activities

___ Assisting children in group classes ___ Administrative work

Do you have experience handling and riding horses? Yes No

Please explain the extent of your horse knowledge/experience, your comfort level around horses, and your willingness to learn to handle horses in therapy lessons:

_____
_____
_____
_____
_____

We ask that all volunteers donate a minimum of a two hour time block.
Please indicate the days and times you are available to volunteer:

Sunday _____

Monday _____

Tuesday _____

Wednesday _____

Thursday _____

Friday _____

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ESSEX EQUESTRIAN CENTER

General Waiver, Release, & Indemnity Agreement

Since all activity involving horses can be dangerous, we require all visitors and riders to assume all risk by signing this release and waiver.

For and in consideration of permitting (name of rider) _____ to enroll in and participate in horse related activities, Essex Equestrian Center, its principals, employees, and its entirety, hereinafter designed as EEC, beginning on (date) _____, the undersigned and his or her parent or legal guardian (1) hereby voluntarily release, waive, discharge, and relinquish any and all actions or causes of action for personal injury, property, or wrongful death occurring to him or her or his or her child and his or her property as a result of engaging in horse related activities and the undersigned (2) and his or her parent or legal guardian does release, waive, discharge, or relinquish any action or causes of action, aforesaid, which may hereafter arise for him or her or his or her child, his or her estate, and agree that under no circumstances will he or she or his or her executors, administrators, and assigns prosecute, present any claim of personal injury, property damage, wrongful death, injury, or loss of animal against EEC or their agents, servants, or employees for any said cause of action, whether the same shall arise by negligence of any said persons or otherwise.

It is the intention of (1)(Guardian) _____ and (2)(Rider) _____ by this instrument, to exempt and relieve EEC from liability for personal injury, property damage, wrongful death, or injury to or loss of animal caused by negligence.

The undersigned (1) and (2) for him/herself, his/her executors, administrators, or assigns agrees that in the event of any action, lawsuit, or claim for liability for personal injury, property damage, wrongful death, or injury to or loss of animal shall be prosecuted against EEC, he or she shall indemnify and hold EEC harmless from any action, lawsuit, or claims or causes of action by whomever made against EEC.

The undersigned (1) and (2) acknowledges that he/she has read this document, and has been fully and completely advised of the potential dangers incidental to engaging in horse riding and horse related activities and is fully aware of the legal consequences of signing this release.

_____	_____	_____
Witness	Signature of Participant (if over 14)	Date
_____	_____	_____
Witness	Signature of Guardian	Date

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Authorization for Emergency Medical Treatment

Circle one: Staff Volunteer Client

Name: _____DOB:_____Age:_____

Parents names (if under 18): _____

Address: _____City:_____State/Zip:_____

Home Phone: _____Work Phone: _____Mobile: _____

Emergency Contact: _____Relation:_____Phone:_____

Emergency Contact: _____Relation:_____Phone:_____

Physician's Name: _____Medical Facility: _____

Phone: _____Preferred Hospital: _____

Insurance Co.: _____Phone: _____Policy #: _____

Policyholder's Name: _____

Authorization for Emergency Medical Treatment

Consent Plan

In the event emergency medical treatment is required due to an injury during the therapy lesson, or while being on the property of the riding center, I **authorize** Horizon Pediatric Consultants, LLC, and/or Riding Center to secure and retain medical treatment and transportation and to release all records upon the request of the authorized individual or agency providing the emergency medical treatment. If the person or persons listed above are unable to be reached, I consent to x-ray, surgery, hospitalization, medication, and any treatment procedure deemed "life-saving" by the physician.

Consent Signature: _____

Parent/Legal Guardian Signature (if under 18): _____

Witness: _____ Date: _____

Non-Consent

I do not give consent for emergency medical treatment/aid in the case of illness or injury while on the property of the Riding Center. In the event that medical treatment is required, I wish for the following procedures to take place:

_____

_____

_____

Consent Signature: _____

Parent/Legal Guardian Signature (if under 18): _____

Witness: _____ Date: _____

Authorizations/Releases

Liability Release

I would like to volunteer/work for the Equine Assisted Therapy program offered by Horizon Pediatric Consultants, LLC, dba Rocking Horse Rehab, at the Essex Equestrian Center. I acknowledge the risks and potential for risks in mounted equine assisted therapies and activities. I hereby, intending to be legally bound, for myself, my heirs, and assigns, executors, or administrators, waive and release forever all claims for damages against Horizon Pediatric Consultants LLC, its owner, officers, directors, instructors, therapists, aides, volunteers and/or employees for any and all injuries and/or losses I may sustain while participating in the "Rocking Horse Rehab" program.

Consent Signature: _____ Date: _____

Parent signature (if under 18): _____ Date: _____

Confidentiality Policy

As a volunteer or staff member for the therapy program, certain medical or sensitive information regarding the clients of HPC may be shared with you in order for you to effectively handle or interact with said clients. Horizon Pediatric Consultants LLC (HPC), shall preserve the right of confidentiality for all individuals in its program. The staff and volunteers shall keep confidential all medical, social, referral, personal, and financial information regarding a client and his/her family. Any information regarding the clients of HPC will be discussed only when pertinent to the effectiveness of the treatment. There shall be no discussions regarding any client or learned personal information about a client outside of the riding center. Any questions or comments should be directed to the therapist in confidence. A staff member or volunteer who breaches confidentiality will be asked to terminate their affiliation with the program.

I understand and will observe the confidentiality policy of Horizon Pediatric Consultants, LLC

Signature: _____ Date: _____

Background Check

I authorize Horizon Pediatric Consultants, LLC 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. I understand that such access is for the purpose of considering my application as an employee/volunteer, and that I expressly DO NOT authorize Horizon Pediatric Consultants, LLC to disseminate this information in any way to any other individual, group, agency, organization, or corporation.

Have you ever been charged or convicted of a crime? (circle one) No Yes

If yes, explain:_____

_____

_____

_____

Current Driver's License Number: _____ State: _____

Signature: _____ Date: _____

Photo Release

I consent to and authorize the use and reproduction by Horizon Pediatric Consultants LLC of any and all photographs and other audio/visual materials taken of me for promotional materials, educational activities, and exhibitions or for any other use for the benefit of the program.

Signature: _____ Date: _____

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Volunteer/Staff Information and Health History

Name: _____DOB: _____Age: _____

Parents/Legal Guardian (if under 18): _____

Address: _____City: _____State/Zip:_____

Home Phone: _____Work Phone: _____ Mobile: _____

How did you learn about the program?: _____

Recent Medical Tests: Last Tetanus Shot: _____ Tuberculosis Test + or – 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 this therapy setting. Address fitness, cardiac, respiratory, bone, or joint function, recent hospitalizations/surgeries, or any lifestyles changes.

_____

_____

_____

_____

_____

Alleriges: _____

Medications: _____

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: _____