



CHAMPLAIN ADAPTIVE MOUNTED PROGRAM

57 East Shore Road, South Hero, VT 05486

802.372.4087 www.vtchamp.org

Volunteer / Staff Information Form and Health History

General Information

Name _____

Address: _____

Phone: _____ Email: _____ Cell#: _____

DOB: _____ Age: _____

Employer / School: _____

Address: _____

Phone: _____

Parent/Legal Guardian (if under 18) Name: _____ Phone _____

Address (if different from above): _____

How long have you lived in Vermont? _____

Are you fulfilling a Community Service requirement? Y/N

If yes, for which school or agency? _____

How did you learn about CHAMP? _____

Do you have previous horse experience? _____

Volunteer interests

Please indicate all areas of interest to you:

CHAMP Program

- Grooming / tacking horses
- Sidewalking with CHAMP riders
- Assisting with morning barn chores
- Helping with facility repairs and maintenance
- Other: Please describe: _____

Special events / administration

- Fundraising events
- Grant writing
- Photography / videography
- Public relations

What days/ times are you available to volunteer? _____



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Health History

Vaccinations

Are you fully vaccinated for Covid-19? Yes _____. No _____

When was your last tetanus shot? _____

Please consult your physician or health department if you are not up to date on these vaccinations.

Have you ever tested positive for Tuberculosis? Yes. ____ No. ____ If yes, when was your last test? _____

General Health

Please describe your current health status, particularly regarding the physical/emotional demands of working in an equine assisted program. Address fitness, cardiac, respiratory, bone or joint function, recent hospitalizations / surgeries, or lifestyle issues.

Are you able to jog next to a trotting horse? Yes _____. No _____

Allergies _____

Medications _____

Confidentiality Agreement

I understand that all information (written or verbal) about participants at CHAMP is confidential and will not be shared with anyone without express written consent of the participant and/or their parent or guardian in the case of a minor.

Signature _____ Date: _____

Liability Release

As a volunteer at the Champlain Adaptive Mounted Program (CHAMP), I acknowledge the risks and potential for risks of a horseback riding program, however, I feel that the possible benefits to myself and the clients worked with are greater than the risks assumed. 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 CHAMP at Good Hope Farm, its board of directors, instructors, therapists, volunteers and/or employees; and PATH International; for any and all injuries and/or losses I/my son/my daughter/my ward may sustain while participating in Equine activities. I also understand that under Vermont Law, an Equine activity sponsor is not liable for an injury to, or the death of a participant in equine activities resulting from the inherent risks of equine activities that are obvious and necessary, pursuant to 12 V.S.A. 1039.

Signature: _____ Date: _____

Print name below if signature is by a parent or guardian – for participants under age 18



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Authorization for Emergency Medical Treatment

Name: _____ DOB: _____ Phone : _____

Address: _____

Physician's Name: _____ Preferred Medical Facility _____

Health Insurance Company: _____ Policy No. _____

Allergies to Medications _____

Current Medications _____

In the event of an emergency contact:

Name: _____ Relation: _____ Phone: _____

Name: _____ Relation: _____ Phone: _____

Name: _____ Relation: _____ Phone: _____

Consent Plan

In the event emergency medical aid/treatment is required due to illness or injury during the process of receiving services, or while on the property, I authorize Champ at Good Hope Farm (Champ) 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.

This authorization includes X-ray, surgery, hospitalization, medication and any treatment procedure deemed "life-saving" by the physician or emergency medical personnel.

This provision will only be invoked if the Emergency Contact persons above are unable to be reached.

Signature of Parent/Guardian: _____ Date: _____



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CHAMP may request you to be part of a promotional press release. For legal reasons, we require that you understand and agree to the releases below by filling them out and signing both.

Participant: _____ DOB: _____ Age: _____

Address: _____

Home Phone: _____

Work Phone: _____

Cell Phone: _____

PHOTO RELEASE

- I do
- I do not

consent to and authorize the use and reproduction by CHAMP of any and all photographs and any other audio-visual materials taken of me/my son/my daughter/my ward for promotional use, educational activities, and exhibitions and for any other use for the benefit of the program.

SIGNATURE _____ Date: _____

Name: _____ Relationship _____

Print name above if signature is by a parent or guardian relationship

INFORMATION FOR PRINT RELEASE

- I do
- I do not

consent to and authorize the use and reproduction by CHAMP of any and all interviews done by members of the press for purposes of promoting the Champlain Adaptive Mounted Program – CHAMP. I will not hold any CHAMP instructor or volunteer or the authors or publishers of any article liable for statements they may make about me and my participation in this program based on the information provided in interviews. I further understand that I am participating solely for the promotion and fundraising to benefit the CHAMP programs and that there will be no compensation made to me by CHAMP or the publishing organizations.

SIGNATURE _____ Date: _____

Name: _____ Relationship _____

Print name above if signature is by a parent or guardian relationship



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CHAMP Background Information Form

Background Information

Have you ever been charged with or convicted of a crime? Yes _____ No _____

If yes, please explain: _____

I, _____ volunteer / staff, authorize CHAMP to receive information from any law enforcement agency, including police departments and sheriff's departments, of this state or any other state of 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 or animals.

I understand such access is for the purpose of considering my applications as a volunteer / employee, and I expressly DO NOT authorize CHAMP, its directors, officers, employees, or other volunteers to disseminate this information in any way to any other individual, group agency, organization, or corporation.

Signature: _____ Date: _____

Current Driver's License Yes _____ No _____. License Number _____ State: _____

Background Check

It has become evident to us that, in our current social and legal climate, we must ask for background checks on our volunteers and employees. Our riders are members of a vulnerable population and we have an obligation to assure them of a safe and comfortable environment in which they can thrive.

We have never had any indication of problems within our organization. We believe our employees and volunteers are people of the highest caliber and are above reproach. However, we must be able to back this claim with official proof.

We hope that you can put yourselves in the position of our riders and their caregivers and understand the need for this requirement. A request for background information is not meant as an insult and should not be taken as such.

We ask that you complete Section II of the Vermont Agency of Human Services Registry Check Form.

Your position as a volunteer of employee is conditional upon receipt of an acceptable report.