

Talisman Therapeutic Riding, Inc.  
172 Blue Ribbon Lane, Grasonville, MD 21638  
443-239-9400 Office  
[www.TalismanTherapeuticRiding.org](http://www.TalismanTherapeuticRiding.org).

## Volunteer Application

### ***Release of Liability Form***

Name of Volunteer \_\_\_\_\_  
Please Print Clearly

I recognize that horseback riding, assisting in riding lessons, caring for, and being in the near vicinity of horses are high risk activities. I hereby agree that my involvement in such activities and/or my presence on TTR premises is at my own risk.

I hereby release TTR, its officers, employees, volunteers and agents from any and all liability arising out of my participation in such activities and/or my presence on TTR premises (including costs and attorney's fees) regardless of whether or not liability is premised on negligent actions or omissions of such released parties or otherwise.

I hereby agree to indemnify and hold harmless TTR, its officers, employees, volunteers and agents from any and all suits, actions, claims of any type arising out of my involvement in such activities and/or my presence on TTR premises whether or not such suits, etc. are premised on negligent actions or omissions of such indemnified parties or otherwise.

I have read this agreement and fully understand its contents.

PLEASE SIGN HERE: \_\_\_\_\_

Parent/Guardian must sign if the volunteer is 17 years old or younger:

Signed \_\_\_\_\_ Date \_\_\_\_\_

#### Authorization for Emergency Medical Treatment Form

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Physician's Name: \_\_\_\_\_ Preferred Medical Facility: \_\_\_\_\_

Health Insurance Company: \_\_\_\_\_ Policy #: \_\_\_\_\_

I am allergic to the following: \_\_\_\_\_

I am taking the current medications: \_\_\_\_\_

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**Volunteer Application**

I have the following ongoing medical condition(s): \_\_\_\_\_

**In the event of an emergency, contact:**

Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Phone: \_\_\_\_\_  
Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Phone: \_\_\_\_\_  
Name: \_\_\_\_\_ Relation: \_\_\_\_\_ 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 the staff of Talisman Therapeutic Riding, Inc. to:

- 1. Secure and retain medical treatment and transportation if needed.
- 2. 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 "lifesaving" by the physician. This provision will be invoked only if the person(s) above is unable to be reached.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian Signature if the volunteer is 17 years old or younger: \_\_\_\_\_

**OR 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.

- Parent or legal guardian will remain on site at all times during equine assisted activities
- In the event emergency treatment/aid is required, I wish the following procedure to take place:

\_\_\_\_\_  
Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian Signature if the volunteer is 17 years old or younger': \_\_\_\_\_

Please return completed forms to: Volunteer Coordinator, TTR, 172 Blue Ribbon Lane Grasonville, MD 21638