Volunteer Registration

PLEASE PRINT

Name _____

Parent or Guardian _____

Address _____

City, State, Zip Code _____

Home Number _____ Cell Phone _____ Cell Phone _____

Volunteer's E-mail _____ Parent E-mail _____

Date of Birth _____ Age _____

Name of School or Occupation _____ Year in School _____
(if applicable)

In case of emergency, who may we contact:

Emergency Contact #1: _____

Home Number _____ Cell Phone _____ Work Phone _____

Address _____

City, State, Zip Code _____

Relationship to Participant _____

Emergency Contact #2: _____

Home Number _____ Cell Phone _____ Work Phone _____

Address _____

City, State, Zip Code _____

Relationship to Participant _____

Completed New Volunteer Orientation:_____ Office Entered by: _____

Revised 2023

DO NOT MAIL. Bring packet to orientation

P.O. Box 376 ▪ Barrington, IL 60011 ▪ walkonfarm.org
Office Phone: (847) 381-4231 ▪ Fax: (847) 381-4288 ▪ Email: walkon@walkonfarm.org
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Authorization for Emergency Medical Treatment Form

Volunteer Name: _____

Physician's Name: _____Phone:_____

Preferred Medical Facility: _____

Health Insurance Company: _____ Policy #: _____

Allergies to Medication: _____

Current Medications: _____

In the event emergency medical aid/treatment is required due to illness or injury during the process of volunteering, or while being on the property of the agency, I authorize **Walk On** to:

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

Please sign only one 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 emergency contact is unable to be reached.

Consent Signature: _____ Date: _____

Volunteer or *if under 18 yrs old* *Parent or Guardian*

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 volunteering 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:

_____

Non-Consent Signature: _____ Date: _____

Volunteer or *if under 18 yrs old* *Parent or Guardian*

Health History

Volunteer Name: _____

Health History

Please describe your current health status, particularly regarding the physical/emotional demands of working in an equine assisted program. Address general fitness, cardiac, respiratory, bone or joint function, any previous surgeries which may hamper your ability to actively participate in an equine assisted program.

_____

_____

_____

_____

_____

_____

Allergies: _____

_____

Medications: _____

_____

Recent Medical Tests: Tetanus Shot Date _____ TB Test + -- Date _____

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: _____

Volunteer or ***if under 18 yrs old Parent or Guardian***

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Photo Release Form

I _____ Do Consent
_____ Do Not Consent

To and authorize the use and reproduction by **Walk On** of any and all photographs and any other audio/visual materials taken of me for promotional material, educational activities, exhibitions or for any other use for the benefit of the center.

Signature: _____ Date: _____
Volunteer or *if under 18 yrs old* *Parent or Guardian*

Social Media Release Form

(Facebook, Instagram, Website)

I _____ Do Consent
_____ Do Not Consent

To and authorize the use and reproduction by **Walk On** of any and all photographs and any other audio/visual materials taken of me for the purpose of electronic social media.

Signature: _____ Date: _____
Volunteer or *if under 18 yrs old* *Parent or Guardian*

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Volunteer Liability Release

WARNING
UNDER THE EQUINE ACTIVITIES LIABILITY ACT, EACH PARTICIPANT WHO ENGAGES IN AN EQUINE ACTIVITY EXPRESSLY ASSUMES THE RISK OF ENGAGING IN AND LEGAL RESPONSIBILITY FOR INJURY, LOSS OR DAMAGE TO PERSON OR PROPERTY RESULTING FROM THE RISK OF EQUINE ACTIVITIES 745 ILCS 47/25

I/we _____ would like to participate in the Walk On volunteer program. I/we acknowledge and accept the risks and potential risks of engaging in equine activities, including but not limited to:

1) The propensity of equines to behave in dangerous ways that may result in injury to the participant.
2) The inability to predict an equine's reaction to sound, movements, objects, persons, or animals.
3) The hazards of surface or subsurface conditions.
4) Collisions with other equines or objects
5) The potential of a participant to act in a negligent manner that may contribute to injury to the participant or others, such as failing to maintain control over the animal or not acting within his or her ability

However, I/we feel the possible benefits to myself/my son/my daughter/my ward are greater than the risks assumed. I/we hereby, intending to be legally bound, for myself, my personal representatives, heirs distributes, guardians, legal representatives, next of kin and assigns, waive and release all claims for damages against Walk On, its owners, lessors, agents, employees, instructors, therapists, volunteers, officers, directors, shareholders and members for any and all injuries and losses I/we may sustain while participating in Walk On's program.

Costs and Fees: In the event the undersigned shall commence litigation in respect to their participation in Walk On's program, the undersigned will be responsible for all costs and expenses, including attorney's fees incurred by BOTH parties as a result of such litigation.

Accident/Medical Insurance: I/we the undersigned agree that should emergency medical treatment be required. I/we have or my own accident/medical insurance company shall pay for all such incurred expenses. I have recorded my accident/medical insurance on Walk On's Authorization for Emergency Medical Treatment form.

Severability: In the event that one or more of the provisions of this Agreement are ever invalidated for any reason by a court of competent jurisdiction, any provision so invalidated shall be deemed severable from the other provisions hereof, and the remaining provisions hereof shall continue to be valid and fully enforceable.

I/WE THE VOLUNTEER OR THE PARENT OR GUARDIAN THEREOF IF UNDER 18 YEARS OF AGE OR OTHERWISE CANNOT CONSENT, THE UNDERSIGNED, HAVE READ AND DO UNDERSTAND THE FOREGOING AGREEMENT WARNINGS, RELEASE AND ASSUMPTION OF RISK AND HAVE READ AND VOLUNTARILY SIGN THIS AGREEMENT AND FURTHER AGREE THAT NO ORAL REPRESENTATIONS, STATEMENTS OR INDUCEMENTS APART FROM THE ABOVE WRITTEN AGREEMENT HAVE BEEN MADE BY WALK ON, IT'S OWNERS, LESSORS,AGENTS,EMPLOYEES, THERAPISTS, INSTRUCTORS, VOLUNTEERS, OFFICERS, DIRECTORS, SHAREHOLDERS AND MEMBERS.

I/WE THE VOLUNTEER OR THE PARENT OR GUARDIAN THEREOF IF UNDER 18 YEARS OF AGE OR OTHERWISE CANNOT CONSENT, THE UNDERSIGNED, CERTIFY THAT I HAVE THE LEGAL AUTHORITY TO EXECUTE THIS AGREEMENT. THIS AGREEMENT SHALL REMAIN VALID UNTIL EXPRESSLY REVOKED BY THE VOLUNTEEROR THE PARENT OR GUARDIAN THEROF IF UNDER 18 YEARS OF AGE OR OTHERWISE CANNOT CONSENT.

Consent Signature: _____ Date: _____

Volunteer or *Parent or Guardian (if under 18 yrs old)*

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NON-DISCLOSURE and CONFIDENTIALITY AGREEMENT

Non-Disclosure and Confidentiality Agreement (the "Agreement") entered into between Walk On, located at 26665 West Cuba Road, Barrington, Illinois 60010, and _____ the "Volunteer"

Walk On is an organization that helps children and adults (the "Participants") with a wide range of disabilities including, but not limited to, Spina Bifida, Cerebral Palsy, Down Syndrome, Autism and spinal cord injuries to better use their minds and bodies through equine assisted activities. Volunteers of Walk On assist the participants with their lessons, work with the horses or assist in the office. Participants expect that their participation in Walk On, the existence and extent of their disabilities, and their experiences with Walk On remain confidential.

Walk On desires to provide to its participants equine assisted activities on a confidential basis.

Accordingly, Walk On and the Volunteer agree as follows:

1. The identity of the Participants will not be disclosed by either Walk On staff or Volunteers without prior written consent of the Participant or their parents/guardians;

2. Information concerning the Participants' disabilities will not be disclosed by Walk On staff or the Volunteer without prior written consent of the Participants' or their parents/guardians;

3. The obligations of Walk On and the Volunteer under this Agreement shall continue after the Participants cease their association with Walk On unless written consent is given by the Participant or their parents/guardians;

4. This Agreement shall be governed by and construed in accordance with the Laws of the State of Illinois;

5. This Agreement constitutes the complete Agreement between Walk On and the Volunteer, and this Agreement may not be modified except in writing signed by the parties hereto.

Read, understood and agreed by:

By_____ By_____

Walk On **Volunteer or** ***if under 18 yrs old*** ***Parent or Guardian***

Date_____ Date_____

Volunteer Handbook Checklist

TO BE SIGNED AFTER COMPLETED VOLUNTEER ORIENTATION

I have received instruction on and have been trained for all volunteer responsibilities and safety rules including, but not limited to the following:

- Illinois Equine Liability Act
- Emergency Information
- Dismissal policy
- First Aid location
- Proper attire
- Volunteer responsibilities
- Leading duties
- Sidewalking duties
- Covid-19 Policies

Volunteer or *if under 18 years old* ***Parent or Legal Guardian***

Print name

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Background Check Authorization

Complete only if you are 18 years or older

I_____, certify under penalty of perjury under state and federal law that the information contained in my volunteer application and /or employment application is complete, true and accurate. I acknowledge that falsification or omission of any information may result in the immediate dismissal or retraction of an offer for employment or as a volunteer.

I authorize Walk On to obtain a background check report, which may include, but is not limited to the following:

- Criminal Records
- Civil Records
- Employment Records
- Personal Identity Verifications
- Credit Report

I authorize all persons and organizations that may have information relevant to this background check to disclose such information to Walk On's authorized agent. I hereby release and hold harmless Walk On and its authorized agent from all claims and liabilities of any nature, which may arise in connection with this background check and the resultant reports(s).

I certify that I have read and understand this Walk On Background Check Authorization and consent to the release of all background check information. I understand that I have specific prescribed rights as a consumer under the federal Fair Credit Reporting Act (FCRA). A photocopy of this authorization will be considered valid.

Print Name:_____
(First) (Middle) (Last)

Former Name(s) and Dates used:

_____
(First) (Middle) (Last) (Date)

Current Address:_____
(Street) (City) (Zip/State)

Previous Address:_____
(Mo/Yr) (Street) (City) (Zip/State)

Social Security Number: _____ DOB:_____

Drivers License Number/State:_____

Consent Signature: _____ Date: _____

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Illinois State Police Search Criminal Record Information Release

I hereby authorize Castle Branch to obtain and subsequently disseminate, and the Illinois Department of State Police to provide and release, conviction information and criminal history record information about me, including, without limitation, for purposes of employment or licensing.

*Signature _____

*Printed Name: _____

*Date: _____

Order number: _____

*Date of birth: _____

Company Name: _____

*Indicates a required field