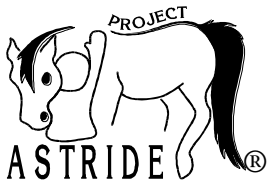


2011 Project ASTRIDE Volunteer Release/Authorization Forms

1. EMERGENCY MEDICAL TREATMENT CONSENT,
AUTHORIZATION, AND RELEASE
2. EMERGENCY MEDICAL TREATMENT NON-CONSENT,
AUTHORIZATION, AND RELEASE
3. CONFIDENTIALITY AGREEMENT
4. DISMISSAL POLICY
5. PHOTO RELEASE AND AUTHORIZATION
6. RELEASE OF LIABILITY



ADAPTED SPECIALIZED TRAINING AND RECREATION
INVOLVING DISABLED EQUESTRIANS

**VOLUNTEER EMERGENCY
MEDICAL TREATMENT CONSENT,
AUTHORIZATION, AND RELEASE**

Volunteer Name _____ Date of Birth _____

Address _____ City _____ State _____ Zip _____

Phone (____) _____ Alternate Phone (____) _____

Designated Contact Person _____ Phone (____) _____

Relationship _____

Physician's or Clinic's Name _____

Address _____ City _____ State _____ Zip _____

Phone (____) _____

Please describe any medical conditions requiring special precautions or treatment and any related medication(s) and dosage(s):

None

If any, please describe: _____

In case of medical emergency, I hereby authorize Project ASTRIDE staff to provide/seek emergency medical treatment as deemed necessary for me/my child (if child is a minor). Project ASTRIDE staff will attempt to reach my "contact person" (if my child is a minor).

Riding instruction will be under strict supervision and, although every effort will be made to avoid accidents and injury, NO LIABILITY shall inure to Project ASTRIDE, its staff, volunteers, or any other related organization or entity.

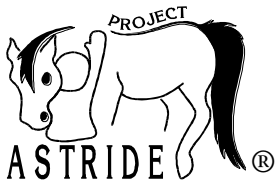
Volunteer Name _____
(Please Print)

Volunteer Signature _____ Date _____

Signature of Parent/Legal Guardian _____ Date _____
(If Volunteer is Under 18 Years of Age)

**IF YOU DO NOT CONSENT TO EMERGENCY MEDICAL TREATMENT, PLEASE REQUEST
AND COMPLETE PROJECT ASTRIDE NON-CONSENT TO EMT.**

(V.E.) Volunteer Emergency Medical Consent,
Authorization, and Release
Rev. 3/2010



ADAPTED SPECIALIZED TRAINING AND RECREATION
INVOLVING DISABLED EQUESTRIANS

**VOLUNTEER EMERGENCY
MEDICAL TREATMENT
NON-CONSENT,
AUTHORIZATION, AND RELEASE**

Volunteer Name _____ Date of Birth _____

Address _____ City _____ State _____ Zip _____

Phone (____) _____ Alternate Phone (____) _____

Designated Contact Person _____	Phone (____) _____
Relationship _____	
Physician's or Clinic's Name _____	
Address _____	City _____ State _____ Zip _____
Phone (____) _____	

Please describe any medical conditions requiring special precautions or treatment and any related medication(s) and dosage(s):

- None
- If any, please describe: _____

In case of medical emergency, I **DO NOT AUTHORIZE** Project ASTRIDE staff to provide/seek emergency medical treatment as deemed necessary for me/my child (if child is a minor).
I request Project ASTRIDE staff to attempt to reach my "contact person" (if my child is a minor).

Riding instruction will be under strict supervision and, although every effort will be made to avoid accidents and injury, NO LIABILITY shall inure to Project ASTRIDE, its staff, volunteers, or any other related organization or entity.

Volunteer Name _____
(Please Print)

Volunteer Signature _____ Date _____

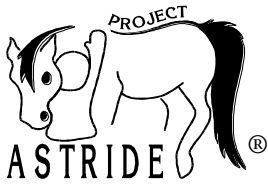
Signature of Parent/Legal Guardian _____ Date _____
(If Volunteer is Unger 18 Years of Age)

**BY FAILING TO CONSENT AND AUTHORIZE PROJECT ASTRIDE STAFF TO PROVIDE/SEEK
EMERGENCY MEDICAL TREATMENT, I UNDERSTAND I MAY PLACE MYSELF AND/OR MY MINOR
CHILD AT RISK SHOULD I OR MY MINOR CHILD SUSTAIN AN INJURY OR ILLNESS AS A RESULT
OF PARTICIPATION.**

Volunteer Name _____
(Please Print)

Volunteer Signature _____ Date _____

Signature of Parent/Legal Guardian _____ Date _____
(If Volunteer is Unger 18 Years of Age)



ADAPTED SPECIALIZED TRAINING AND RECREATION
INVOLVING DISABLED EQUESTRIANS

**VOLUNTEER CONFIDENTIALITY
AGREEMENT**

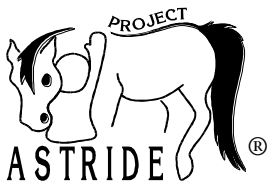
Project ASTRIDE shall maintain the right to privacy and the right of confidentiality of all Participants and Volunteers involved in its programs and services. The instructors, coordinators, and Volunteers, which are authorized access to information on any Participant or Volunteer in any Project ASTRIDE program, hereby agree to keep all medical, personal, social, and referral information confidential. Any person violating the terms of this Confidentiality Agreement may be immediately reassigned or terminated from further participation in the program.

I HAVE READ, UNDERSTAND, AND AGREE TO ABIDE BY THIS CONFIDENTIALITY AGREEMENT.

Volunteer Name _____
(Please Print)

Volunteer Signature _____ Date _____

Signature of Parent/Legal Guardian _____ Date _____
(If Volunteer is Unger 18 Years of Age)



ADAPTED SPECIALIZED TRAINING AND RECREATION
INVOLVING DISABLED EQUESTRIANS

VOLUNTEER DISMISSAL POLICY

Project ASTRIDE is committed to providing a safe, therapeutic riding experience to all Participants. To assure the rights of all participants and volunteers are protected, the following actions by participants and their family members, visitors, and volunteers are considered contrary to the goals of Project ASTRIDE. Volunteers exhibiting these actions may be asked to immediately leave the activity site and/or be dismissed from the program.

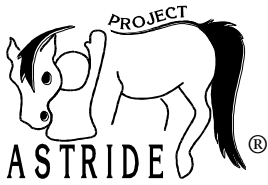
- Violating the data privacy rights of any Participant.
- Use of any mood-altering chemicals, unless prescribed by a physician.
- Deliberate and repeated use of offensive language.
- Inappropriate physical contact with a participant, volunteer, or other staff member.
- Sexual, racial, or unethical harassment of any participant, volunteer, or staff member.
- Action or conduct that may disrupt a session or cause a safety concern, as determined by the instructor(s).
- Theft of Project ASTRIDE property.
- Gross negligence or willful misconduct causing damage or abuse of Project ASTRIDE property.
- Abuse of horses, volunteers, participants, or any staff member.
- Smoking on any activity site premises.
- Bringing pets and dogs without proper pre-authorization from the facility owner.
- Carelessness or negligence in the performance of volunteer or staff duties.
- Engaging in deception, fraud, or misrepresentation in any manner whatsoever, involving Project ASTRIDE.

I have received a copy of Project ASTRIDE's Dismissal Policy and understand the grounds for dismissal from Project ASTRIDE.

Volunteer Name _____
(Please Print)

Volunteer Signature _____ Date _____

Signature of Parent/Legal Guardian _____ Date _____
(If Volunteer is Unger 18 Years of Age)



ADAPTED SPECIALIZED TRAINING AND RECREATION
INVOLVING DISABLED EQUESTRIANS

**VOLUNTEER PHOTO RELEASE
AND AUTHORIZATION**

The undersigned hereby:

Grants Project ASTRIDE permission to use still, moving, and/or television pictures of me for publicity purposes. This may include items posted to Project ASTRIDE's website, www.astride.org.

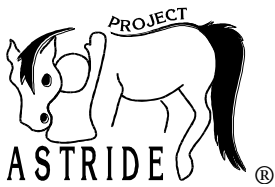
DO NOT grant Project ASTRIDE permission to use still, moving, and/or television pictures of me for publicity purposes.

DO NOT grant Project ASTRIDE permission to use still, moving, and/or television pictures of me for purposes of publicity, but they may be distributed to participants for memorabilia purposes.

Volunteer Name _____
(Please Print)

Volunteer Signature _____ Date _____

Signature of Parent/Legal Guardian _____ Date _____
(If Volunteer is Under 18 Years of Age)



ADAPTED SPECIALIZED TRAINING AND RECREATION
INVOLVING DISABLED EQUESTRIANS

**VOLUNTEER
RELEASE OF LIABILITY**

It is our duty to warn you that as in any sport, working with and riding horses may lead to accidents that could result in injuries, illness, and/or have catastrophic results. Therefore, having been fully apprised of such possibilities, the undersigned does hereby forever release, acquit, discharge, and hold harmless Project ASTRIDE, Project ASTRIDE's owners, officers, trustees, agents, employees, volunteers, successors, representatives, and assigns, for all manner of claims, demands, and damages of every kind and nature whatsoever, which may now exist or may hereafter accrue, against Project ASTRIDE, Project ASTRIDE's officers, trustees, agents, employees, volunteers, representatives, successors, or assigns, on account of or resulting in, any injuries, illness, physical or mental condition, known or unknown, including any emergency treatment, as a result of, or in any way associated with, the acts of Project ASTRIDE, Project ASTRIDE's officers, trustees, agents, employees, volunteers, representatives, successors, or assigns, including but not limited to, acts of negligence or gross negligence, in providing therapeutic riding programs and services, or in any way incidental thereto.

I have _____ attended the Volunteer Training held on _____

OR

_____ viewed the entire Training Video on _____

_____ Date _____
(Volunteer Signature)

_____ Date _____
(Staff Signature)

Volunteer Name _____
(Please Print)

Volunteer Signature _____ Date _____

Signature of Parent/Legal Guardian _____ Date _____
(If Volunteer is Unger 18 Years of Age)