



Mephibosheth Farms Angelic Riders

VOLUNTEER APPLICATION FORM

Date of Application: ____ / ____ / ____

Name: _____ **Age:** _____

Phone: (H) _____ (C) _____ **Text?** _____

E-Mail: _____

Address: _____

City: _____ **State** _____ **Zip Code** _____

Do you need to complete a specific number of hours? How many? _____

If you are under the age of 18:

Parents/Guardians names: _____

Phone: (H) _____ (C) _____

E-Mail: _____

How did you hear about Angelic Riders? ____ **Internet** ____ **Family or friend** ____ **School** ____ **Other** _____

Do you have any special skills to offer?

____ **Photograph/Video**

____ **Fund Raising**

____ **Public Relation**

____ **Volunteer Recruitment**

____ **Newsletter**

Other: _____

WARNING!

Under North Carolina Law, an equine activity sponsor or equine professional is not liable for an injury to or the death of a participant in equine activities resulting exclusively from the inherent risks of equine activities.

[Chapter 99E of the North Carolina Statutes](#)



Mephibosheth Farms Angelic Riders

Release Form

Liability Release:

As a volunteer at Mephibosheth Farms Angelic Riders, Inc., I acknowledge the risks and potential for risks of a horseback riding program. However, I feel that the possible benefits to myself and the participants I work with are greater than the risk 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 Michael and Ruby Harris, Mephibosheth Farms Farm, Inc., Mephibosheth Farms Angelic Riders, Inc., its Board of Directors, instructors, volunteers and/or employees for any and all injuries and/or losses I may sustain while participating in Mephibosheth Farms Angelic Riders, Inc.

Signature: _____ Date: _____

Print name: _____

Parent/Guardian Signature (if under 18): _____

Photo Release (check one):

I ☐ do ☐ do not consent to and authorize the use and reproduction by Mephibosheth Farms Angelic Riders, Inc. of any and all photographs and any other audio/visual materials taken of me and/or my family for promotional materials, educational activities, exhibitions or for any other use for the benefit of the program. Additionally, I ☐ do ☐ do not consent to and authorize the use of any testimonial and spoken quotes from me for promotional materials, marketing purposes or any other use for the benefit of the program.

Signature: _____ Date: _____

Print name: _____

Parent/Guardian Signature (if under 18): _____

Confidentiality Agreement:

I understand the expectation that all information related to the participants of Mephibosheth Farms Angelic Riders is considered confidential in nature. I further understand the liability of persons with access to rider information and hereby agree to protect and preserve the confidential nature of all rider information to which I have access.

Signature: _____ Date: _____

Print name: _____

Parent/Guardian Signature (if under 18): _____

WARNING!

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Mephibosheth Farms Angelic Riders

Medical Form

In the event emergency medical 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 Mephibosheth Farms Angelic Riders to:

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

Consent Plan:

___ I **DO** give authorization that may include x-ray, surgery, hospitalization, medication, and any treatment procedure deemed "lifesaving" by the physician. This provision will only be invoked if the emergency contact person(s) above is unable to be reached.

Signature: _____ **Date:** _____

Print name: _____

Parent/Guardian Signature (if under 18): _____

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. In the event emergency treatment is required, I wish the following procedures to take place: _____

Signature: _____ **Date:** _____

Print name: _____

Parent/Guardian Signature (if under 18): _____

If you consent please fill out the information below:

DOB: ____/____/____

Participant's Name: _____

Physician's Name: _____

Medical Facility: _____

Health Insurance Company: _____ Policy #: _____

Allergies to medications: _____

Current medications: _____

In the event of an emergency, contact: _____

Name: _____ Relation: _____ Phone: _____

Name: _____ Relation: _____ Phone: _____