



**SUNCATCHER**  
 Therapeutic Riding Academy, Inc.  
 P O Box 3975  
 Rapid City, SD 57709  
 Ph 605-673-2935 fax 605 673-4747

SunCatcher TRA@aol.com

www.suncatchertra.org

**RELEASE FORMS**

**Attach Volunteer/Staff Registration and Health Information**

**Volunteer/Staff's Name** \_\_\_\_\_

**Date** \_\_\_\_\_

**Publicity Release:** I hereby **do consent** \_\_\_\_\_ / **do not consent** \_\_\_\_\_ to give permission for SunCatcher to use any photographs or audio/visual materials for promotion, education, publication or exhibition for the purposes of conveying information concerning the above named applicant and/or SunCatcher Therapeutic Riding Academy, Inc.



signature of parent, legal guardian, volunteer/staff if own guardian, or authorized person

witness

date

**Liability Release:** I acknowledge the risks and potential risks of horseback riding, unmounted equine activities, driving, vaulting and other equine events. However, I feel that the possible benefits to the participant, and to myself as a volunteer/staff member, are greater than the risk assumed. I hereby, intending to be legally bound, for myself, my heir and assigns, executors or administrators, waive and release forever all claims for damages against SunCatcher Therapeutic Riding Academy, Inc., its Board of Directors, staff, consultants, and volunteers but not limited thereto, for any and all injuries and/or losses which may be sustained while volunteering or working at SunCatcher Therapeutic Riding Academy, Inc.



signature of parent, legal guardian, volunteer/staff if own guardian, or authorized person

witness

date

**Background Information**

Have you ever been charged with or convicted of a crime? No Yes; Please explain \_\_\_\_\_

I, \_\_\_\_\_(volunteer/staff), authorize SunCatcher Therapeutic Riding Academy, Inc. to receive information from any law enforcement agency, including police departments and sheriff's departments, of the state or any other state or federal government, to the extent permitted by state and federal laws, 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.

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

Signature \_\_\_\_\_



(Volunteer/Staff)

Date \_\_\_\_\_



CURRENT DRIVER'S LICENSE Yes No LICENSE NUMBER \_\_\_\_\_

STATE \_\_\_\_\_

**Authorization for Emergency Medical Treatment Form**

I hereby give permission for the applicant as named below, that in the event emergency medical aid/treatment is required due to illness or injury during the process of volunteering/working, or while being on the property of the agency, I authorize SunCatcher 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.

Volunteer/Staff Name \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

Please list two people who may be contacted in case of emergency.

Name \_\_\_\_\_ Phone \_\_\_\_\_

Name \_\_\_\_\_ Phone \_\_\_\_\_

Physician's Name \_\_\_\_\_

Preferred Medical Facility \_\_\_\_\_

Health Insurance Co. \_\_\_\_\_ Policy # \_\_\_\_\_

**Consent Plan:** This authorization includes x-ray, surgery, hospitalization, medication and any treatment procedure deemed "life saving" by the physician. This provision will be invoked only if the person(s) listed as guardian or emergency contacts is (are) unable to be reached. **(signature required)**



**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 volunteering/working with SunCatcher TRA or while being on the property of the agency. In the event emergency treatment/aid is required, I wish the following procedures to take place: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



\_\_\_\_\_  
signature of parent, legal guardian, applicant if own guardian, or authorized person



witness



\_\_\_\_\_  
date

Name \_\_\_\_\_

Phone(s) \_\_\_\_\_

Address \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

For Office Use Only:  
App Rec'd: \_\_\_\_\_  
Complete? \_\_\_\_\_  
Ref by: \_\_\_\_\_  
Vol: New Current Past  
Data Entry:  
CS SpS DB Sch'd Conf'd  
Comments: \_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_ We are unable to obtain signatures at this time. A copy of this section has been sent to the appropriate individual for signatures and will be mailed to SunCatcher Therapeutic Riding Academy, Inc., prior to the applicant's participation in the program.