Day Program
Volunteer/Intern Liability Release

As a volunteer at Hinds' Feet Farm, I acknowledge the risks and potential for risks of a volunteering in community-based program serving persons with disability. However, I feel that the possible benefits to the clients and myself I work with are greater than the risk assumed. Thereby, intending to be legally bound: for myself, my heirs and assigns, executors or administrators, waive and release forever all claims for damages against Hinds' Feet Farm, its board of directors, instructors, therapists, volunteers and/or employees for any and all injuries and/or losses I may sustain while participating at Hinds' Feet Farm.

Warning: Under North Carolina Law, Chapter 99 E of the North Carolina General Statues, an equine activity sponsor or equine professional is not liable for an injure to or the death of a participant in equine activities resulting exclusively from the inherent risks of equine activities.

Date:________________Signature:____

Print Name:____

Parent/Guardian Signature for Volunteers under 18 years old must sign below.

Date:________________Siganture:____

Relationship:________________ Print Name:____

Day Program
Authorization for Emergency Medical Treatment

Please Print all information

First Name:____________________Last Name:____________________

Date of Birth:__________Home Phone:____________Cell:____________

Address:________________City:__________State:_____Zip:______

Physicians 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:____________

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 Hinds' Feet Farm 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 and Non Consent Plan Choices (please check one):

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 person (s) above is unable to be reached.

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/aid is required, I wish the following procedures to take place:

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Date:__________Authorized Signature:____________________________

Print Name:______________________________Phone #:____________

Address:________________City:__________State:_____Zip:______

Individual, Parent, or Legal Guardian signed in the presence of operating center staff.
Staff Siganture:____________________Title:__________ Date:________

*Any personal or contact information submitted to Hinds' Feet Farm is strictly confidential and will be maintained solely by the organization.