Kent Association of Riding Therapy, Inc.

P. O. Box 126 Worton, MD 21678

VOLUNTEER
INFORMATION AND EMERGENCY MEDICAL TREATMENT FORM

INFORMATION

Volunteer Name: _____ Date of Birth: _____ Age: _____
Address: _____ Home Phone: _____
City: _____ State: _____ Zip: _____
Cell Phone: _____ Email: _____
Parent/Legal Guardian/Caregiver: Name, Address, Phone (if applicable): _____
_____

How did you learn about KART? _____

Check areas you are interested in:

Program Volunteer	Competition	Administration
Horse leader	Horse Show	Antiques Show
Sidewalker		Fund raising
Stable management		Newsletter
Classroom		Volunteer recruitment
		Photography/Video

EMERGENCY MEDICAL TREATMENT

In the event emergency medical aid/treatment is required due to illness or injury during the process of providing services, or while on the property of the agency, I authorize Worthmore, LLC and/or KART to secure and retain medical treatment and transportation if needed. This also means permission to call 911.

In case of Emergency contact: _____ Phone: _____
Or Contact: _____ Phone: _____

Emergency medical aid/treatment may include x-ray, surgery, medication and any treatment procedure deemed "lifesaving" by the physician.

ALLERGIES _____

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 KART's program.

Signature: _____ Date: _____
Signatory MUST be 18 years or older