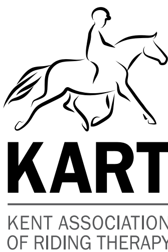

P. O. Box 126 Worton, MD 21678

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? ____

Please 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