Revised January 2024

Checked and Approved by: _____

Date: _____

Chimp Mail	___
Volunteer Contact	___
Vol. Emergency	___
Vol. Spreadsheet	___
Salesforce	___
Name Tag	___
Scanned	___
Attached	___
Master Mailing List	___
Ready to be Filed	___

*Staff use only

2024
New Kingdom Trailriders
Volunteer UPDATE Forms

Name: _____

Phone number: _____

Email: _____

Preferred Method of Contact: ☐ Phone ☐ Email

Address:

_____

_____

*If there is an additional information you need to update it is your responsibility to email Monika at Monika@nktriders.org

Additional Volunteer Information

The collection of this will help us provide additional information for grant funding and will assist with collection of overall statistical data for our organization.

Which county do you reside in?

_____

What is your race or Ethnicity?

Asian ☐
Black or African American ☐
Hispanic or Latino ☐
Middle Eastern or North African ☐
Multiracial or Multiethnic ☐
Native American or Alaska Native ☐
Native Hawaiian or other Pacific Islander ☐
White/Caucasian ☐
Another race or ethnicity_____

Are you or a member of your family a veteran?

No ☐ Yes ☐ If, so who _____

Volunteer Apparel Sizes

There may be a time that clothing items are given away at no cost to you. Having this information allows us to not have to guess on sizing.

**There will be times where your sizes are collected for specific events for easier accessibility.*

T-Shirt Size _____

Long Sleeve Size _____

Hoodie/Jacket Size _____

New Kingdom Trailriders

Authorization for Emergency Medical Treatment Form

☐ Participant ☐ Staff ☐ Volunteer

Name: _____DOB: _____Phone:_____

Address: _____

Street city State zip

Physician's Name: _____Preferred Medical Facility_____

Health Insurance Co: _____Policy #: _____

Allergies to medications: _____

Current medications:_____

Medical Conditions/Special Accommodations Needed:

_____

_____

_____

In the event of an emergency, contact:

Name:_____ Relation: _____ Phone: _____

Name:_____ Relation: _____ Phone: _____

Name:_____ Relation: _____ Phone: _____

In the event of 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 **New Kingdom Trailriders t**o:

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 Plan
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.

Date: _____ Consent Signature:_____
Client, Parent or Legal Guardian

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

☐ Parent or legal guardian will remain on site at all times during equine assisted activities
☐ In the event emergency treatment/aid is required, I wish the following procedure to take place.

Date:_____ Consent Signature:_____