The Luci Center
575 Moody Pike
P.O. Box 936
Shelbyville, KY 40065
502-220-4308 www.thelucicenter.org

Volunteer Information Form

Name: ____

Date of Birth: __________________________ Age: ______ 14 or under? O Yes O No

Home Phone: ______________________________ Cell Phone: ____________________________

Home Address: ___________________________ City: ___________ State: ___ Zip: ______

Work Phone: _____________________________ E-mail Address: _________________________

Work Address: _______________________ City: ___________ State: ____ Zip: ______

Parent/Guardian Name and Address (if applicable): __________________________________

If student, name of school: ____________________________________ City: _______________

How did you learn about **The Luci Center**? _______________________________________

Check which areas you are interested in:

Program Volunteer	**Competition**	Administration
O Leading a horse O Sidewalking with a student O Stable management O Shetland Club (Ages: 10-15)	O Horse Show O Special Olympics	O Public relations O Fund Raising O Newsletter O Volunteer Recruitment O Photography/Video O Budget and Finance O Future Planning

Photo Release

I consent to and authorize the use and reproduction by **The Luci Center** of any and all photographs and any other audiovisual materials taken of me for promotional printed material, educational activities, exhibitions or for any other use for the benefit of the program.

Date: ____________________ Signature: ______________________________________

Liability Release

As a volunteer at **The Luci Center**, I acknowledge the risks of a horseback riding program. However, I feel that the possible benefits to myself and the clients I work with are greater than the risk assumed. I hereby, intending to be legally bound, for myself, my heirs and assigns, executors or administrators, waive and release forever all claims for damage against **The Luci Center**, its board of directors, instructors, therapists, volunteers and/or employees for any and all injuries and/or losses I may sustain while participating in **The Luci Center's program**.

Date: ____________________ Signature: ___________________________________

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Volunteer's Authorization for Emergency Medical Treatment

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 The Luci Center 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's Name: ____ Phone: ________________________

Address: ____

In the event, I cannot be reached, contact: ___________________________ Phone: __________________

Contact: ___________________________ Phone: __________________

Physician's Name: ____

Preferred Medical Facility: ____

Health Insurance Co.: _________________________________ Policy #: ___________________________

Select One Plan

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 below is unable to be reached.

Date: _______________ Consent Signature: ____
(Volunteer, Parent or Guardian)

Print Name: _____________________________________ Phone: ______________________________

Address: ____

Date: _______________ Consent Signature: ____

(Volunteer, Parent or 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. In the event emergency treatment/aid is required. I wish the following procedures to take place.

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Date: _______________ Non-Consent Signature: ____

(Client, Parent or Guardian)

Print Name: _____________________________________ Phone: __________________________

Address: ____