APPENDIX 5A-VR1

Michigan 4-H Proud Equestrians Program (PEP)
Volunteer Registration and Emergency Treatment Form

This form is valid for a period of one year from the date signed.

No individual can be accepted as a volunteer in a Michigan 4-H Proud Equestrians Program until this form has been completed by his/her parent(s)/guardian or by the individual if he/she is a legally competent adult 18 years of age or over.

Date__________________________ ❑ New Volunteer ❑ Return Volunteer

Volunteer: Full Name ____ Date of Birth__________________________
Mailing Address ____
City ____ State __________________ Zip_______________________
Home Phone (_______)___________________ Work Phone (_______)___________________
Previous Experience with Horses____

Parent/Guardian (If Under 18): Full Name____ Phone (_______)________________
Mailing Address ____
City ____ State __________________ Zip_______________________

Physician: Name ____ Phone (______)________________
Address ____
City ____ State __________________ Zip_______________________

Person who should be notified in case of emergency in absence of parent/guardian:
Name____ Phone (______)________________
Relationship to Volunteer____

AUTHORIZATION FOR PURPOSE OF PROVIDING MEDICAL TREATMENT

You are being asked to complete this form to give an appropriate medical facility permission to treat ___________________________ _____________________________(volunteer's name) for minor injury or medical problems. In the event of serious injury or illness, the parent/guardian or person listed above will be contacted; treatment will proceed before contacting them only if the situation is urgent and does not permit delay.

Preferred Medical Facility ____

Is there a medical condition, allergy, etc., requiring special precaution or treatment? ❑ Yes ❑ No
If Yes, please describe:____

Medications currently being used? ❑ Yes ❑ No If Yes, please list name, purpose and dosage: ___________________
____

In case of medical emergency: The undersigned authorizes the Michigan 4-H Proud Equestrians Program instructor and/or program coordinator to seek any medical and/or surgical treatment necessary for the care of ____________________________________ who is participating as a volunteer in the Michigan 4-H Proud Equestrians Program with parent/guardian permission (if under 18 years).

HEALTH INSURANCE

Name of Policyholder/Relationship to Participant:____
Policyholder's address____
Please attach a photocopy of both sides of your insurance card (preferred) OR complete the insurance information requested here.
Name and Address of Insurance Company____
Insurance Company Phone Number (______)_________________ **Policy Number**____
Name of Policyholder's Employer____

REQUIRED SIGNATURES

The above designated person(s) is(are) hereby authorized to incur medical costs necessary to provide medical treatment for said participant for which we shall be fully responsible. We also authorize the medical facility to release any and all information required to complete insurance claims and also authorize insurance payment directly to the medical facility.

Signature: ____ **Date:**________________________
Parent(s) / Guardian / Adult Volunteer (Circle appropriate title)

Witness:____

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