



**Disability Resource Association**  
420 South Truman Blvd.  
Crystal City, MO. 63019  
Phone (636) 931-7696 Fax (636) 931-4863  
**Volunteer Information and Release Form**  
**DRA Healing With Horsepower Equine-Assisted Therapy**

**Volunteer Information**

Volunteer \_\_\_\_\_ Date \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_  
Zip Code \_\_\_\_\_ Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_  
Parent or Guardian (if applicable) \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_  
If student, name of school \_\_\_\_\_  
In Case of Emergency, Contact \_\_\_\_\_ Phone \_\_\_\_\_  
Contact \_\_\_\_\_ Phone \_\_\_\_\_

How did you learn about DRA Healing With Horsepower Therapy \_\_\_\_\_  
\_\_\_\_\_

Do you have experience with horses? \_\_\_\_\_ Please specify \_\_\_\_\_  
\_\_\_\_\_

Do you have any physical limitations? \_\_\_\_\_ Please specify \_\_\_\_\_  
\_\_\_\_\_

**Check areas you are interested in and times you are available**

\_\_\_\_\_ leading a horse      \_\_\_\_\_ side-walker      \_\_\_\_\_ groom  
Monday \_\_\_\_\_ am \_\_\_\_\_ pm      Thursday \_\_\_\_\_ am \_\_\_\_\_ pm  
Tuesday \_\_\_\_\_ am \_\_\_\_\_ pm      Friday \_\_\_\_\_ am \_\_\_\_\_ pm  
Wednesday \_\_\_\_\_ am \_\_\_\_\_ pm

**Liability Release**

\_\_\_\_\_ (Volunteer's Name) would like to participate in the DRA Healing With Horsepower Equine-Assisted Therapy Program. I acknowledge the risks and potential for risks of horseback riding, Therapeutic, Sports, Hippotherapy, and Equine Assisted Psychotherapy; however, I feel that the possible benefits to myself/ my son /my daughter/ my ward and the DRA consumers are greater than the risk assumed.

**In consideration of the right to participate in the DRA Healing With Horsepower Equine-Assisted Therapy Program:**

- 1. I, individually and on behalf of my son/daughter/ward, acknowledge and fully understand that in connection with such participation: (a) I will be engaging in activities that involve a risk of injury; (b) there is a risk of injury which may result from the inaction or negligence of others; and (c) there may be risks which are not known to me or reasonably foreseeable. I hereby voluntarily and expressly elect to accept and solely assume all such risks of injury, which may be suffered by me or my son/daughter/ward in connection with participating in DRA Healing With Horsepower Equine-Assisted Therapy Program.**
  
- 2. I, individually and on behalf of my son/daughter/ward, and further on behalf of myself, my agents, attorneys, representatives, successors, heirs and assigns, and anyone claiming by or through or under me or my son/daughter/ward, hereby release, discharge, and hold harmless Disability Resource Association and its officers, directors, employees, agents, attorneys, representatives, successors, heirs and assigns from any claims, damages, causes of action, suits, costs including attorney fees, damages, expenses, and liabilities of every kind, character and description, either direct or consequential, whether known or unknown, existing or which may hereinafter accrue or arise out of my or our participation in the DRA Healing With Horsepower Equine-Assisted Therapy Program.**

**I ACKNOWLEDGE THAT I HAVE READ AND THAT I UNDERSTAND EACH AND EVERY ONE OF THE ABOVE PROVISIONS IN THIS AGREEMENT AND AGREE TO BE BOUND BY THEM.**

Date \_\_\_\_\_ Signature \_\_\_\_\_  
(Volunteer, Parent, Guardian)

**Photo Release**

**I hereby consent to and authorize the use and reproduction by DRA Healing With Horsepower Equine-Assisted Therapy of any and all photographs and any other audio-visual materials taken of me/ my son/ my daughter/ my ward for promotional printed material, educational activities, or for any other use for the benefit of the program. I understand the volunteer's name may appear with a photo or in printed material.**

Date \_\_\_\_\_ Signature \_\_\_\_\_  
(Volunteer, Parent, Guardian)