

**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 email address \_\_\_\_\_

**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:** \_\_\_\_\_