Healing Strides of VA

PO Box 456 * 672 Naff Road
Boones Mill, VA 24065
P(540) 334-5825 F(540) 334-2941
www.healingstridesofva.org

Information Form

Registration Checklist: *Make sure **all** components below are returned with the packet*

- ☼ Participant Registration and Release Form
- ☼ Authorization for Emergency Medical Treatment
- ☼ Participant Information Survey
- ☼ Participant's Consent for Release of Information
- ☼ Health Care Provider – Cover Letter
- ☼ Current Medical Status (signed by a health care provider)

Therapeutic Horsemanship Lessons are taught by a PATH Certified Instructor. Healing Strides of VA is an Educational Facility and will have Instructors in Training that will also work with your participant. Each lesson will last 55 minutes and the time on the equine will be approximately 45 minutes, once per week. You may schedule your lessons with the Schedule Coordinator.

Fee Schedule

1) Therapeutic Horsemanship - Riding $35.00 per lesson. Horsemanship - Riding $45.00 per lesson.
2.) Paid in Full at a discounted rate at the time or before the first lesson
3.) Paid in two installments at a discounted rate (beginning of session and again at the 6 week mark)
4.) Monthly Tuition Payment: this is due the first week of each month for four lessons at a discounted rate. If not paid during the first week of the month, the cost will be at the regular weekly rate. (If there are five lesson days that month you will pay for five lessons at the beginning of the month at the discounted rate)

Make-Up Lesson Policy:

Healing Strides reserves the right to cancel due to inclement weather. You will be offered a make-up time. If you cannot be at the make-up lesson you will forfeit your lesson. You are allowed one (1) make-up lesson per session which is on a scheduled day and time assigned by the Schedule Coordinator or your Instructor. If you choose not to come to your lesson because of other plans made you will forfeit your lesson. Please contact the office if you have any questions at (540)334-5825.

Session Dates:

Spring:	March 16-June13 (12 weeks)
Summer:	June 22-Aug 1 (6 weeks)
Fall:	Aug 10 – Nov 7 (12 weeks)
Holiday:	Nov 9 – Dec 20 (5 weeks)

Payments:

Can be mailed or placed in the lock box outside the office area. Please write the participants name on the memo line when making a payment by check. When paying by cash, please write the participants name and the program the payment is to cover on the envelope provided at office.

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Participant Registration and Release Form

PLEASE COMPLETE THIS FORM

Client: _____ Date of Birth: _____

Street: _____

City: _____ State: _____ Zip: _____Email_____

Home Phone:_____ Work:_____ Cell:_____

Parents/Guardian/Spouse: _____ Phone:_____

Street:_____ City:_____ State:_____ Zip:_____

School or Institution presently attending (if applicable):_____

In case of an emergency, Contact: _____ Phone: _____

Contact: _____ Phone:_____

Liability Release

_____ AS A CLIENT WITH THE HEALING STRIDES OF VA, I ACKNOWLEDGE AND UNDERSTAND THE RISKS AND POTENTIAL RISKS OF A HORESBACK RIDING PROGRAM INCLUCING BUT NOT LIMITED TO, (i) THE PROPENSITY OF AN EQUINE TO BEHAVE IN DANGEROUS WAYS, WHICH MAY RESULT IN INJURY OR DEATH TO THE PARTICIPANT OR DAMAGE TO PROPERTY; (ii) THE INABILITY TO PREDICT AN EQUINE'S REACTION TO SOUND, MOVEMENTS, OBJECTS, PERSONS OR ANIMALS; (iii) HAZARDS OF SURFACE OR SUBSURFACE CONDITIONS WHETHER KNOWN OR UNKNOWN; (iv) THE CONDITION AND AGE OF THE EQUIPMENT OR TACK, HOWEVER, I FEEL THAT THE POSSIBLE BENEFITS TO MYSELF/MY SON/MY DAUGHTER/MY WARD ARE GREATER THAN THE RISK ASSUMED. I HEREBY, INTENT TO BE LEGALLY BOUND, FOR MYSELF, MY HEIRS AND ASSIGNS, EXECUTORS OR ADMINISTRATORS, AND WAIVE AND RELEASE FOREVER ALL CLAIMS FOR DAMAGES AGAINST HEALING STRIDES OF VA AND ITS BOARD OF DIRECTORS AND EMPLOYEES, INSTRUCTORS, THERAPISTS, AIDES, VOLUNTEERS AND THEIR RESPECTIVE FAMILIES, FOR ANY AND ALL INJURIES AND/OR LOSSES I MAY SUSTAIN WHILE PARTICIPATING IN HEALING STRIDES OF VA. I FURTHER CERTIFY THAT THE FOREGOING STATEMENTS AND REPRESENTATIONS ARE BEING MADE BY ME KNOWINGLY, FREELY AND VOLUNTAIRILY AND I UNDERSTAND THAT HEALING STRIDES OF VA IS EXPRESSLY RELYING UPON THE FOREGOING STATEMENTS AND REPRESENTATIONS IN PERMITTING ME TO PARTICIPATE IN HEALING STRIDES OF VA.

Date: _____ Signature of Client/Parent/ Guardian/ Caregiver:_____

PHOTO RELEASE
___I CONSENT TO AND AUTHORIZE THE USE AND REPRODUCTION BY HEALING STRIDES OF VA, OF ANY AND ALL PHOTOGRAPHS AND ANY OTHER AUDIOVISUAL MATERIALS TAKEN OF ME/MY SON/MY DAUGHTER/MY WARD FOR PROMOTIONAL MATERIAL, EDUCATIONAL ACTIVITES, EXHIBITIONS OF FOR ANY OTHER USE FOR THE BENEFIT OF THE PROGRAM
___I DO **NOT** CONSENT TO THE ABOVE **PHOTO RELEASE**

SIGNATURE: _____DATE_____
PARENT/GUARDIAN/CAREGIVER:_____DATE_____
(Please circle one)

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Authorization for Emergency Medical Treatment Form

In the event emergency medical aid/treatment is required due to illness or injury during the process of receiving/giving services, or while being on the property of the agency or boarding facility, I authorize Healing Strides of VA 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.

Name(print) _____Phone: _____Cell/work: _____

Address: _____

In the event an emergency occurs, please contact:

Contact/relation: _____Phone:_____

Contact/relation: _____Phone: _____

Allergies: _____

Physician's Name: _____Phone: _____

Preferred Medical Facility:

_____

Health Insurance Co. :* _____

Policy #: _____

**If readily available*

Consent Plan

This authorization includes X-ray, hospitalization, medication and any treatment procedure deemed "life saving" by the physician. This provision will only be invoked if the person consenting below is non-responsive in a medical emergency.

Date: _____Consent

Signature:_____*Client, Volunteer, Parent, Guardian, Caregiver*

Print Name_____

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Participant Information Survey

Name: Age: Ht: Wt:

School/Work: Grade:

Physical Limitations (include adaptive equipment used):

Cognitive Limitations (include reading level and number of directions one can follow):

Communication Style:

Behaviors:

Sensory Issues:

Special Concerns:

Interests/Hobbies:

Motivators:

Fears:

Goals:

Precautions:

Current Therapies:

I authorize release of this information to Healing Strides of VA volunteers:

Name _____ Date _____

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Participant's Consent for Release of Information

I hereby authorize: _____
(person or facility)

to release information from the records of: _____ DOB: _____
(participant's name)

The information is to be released to: _____
(center or therapist's name)

for the purpose of developing an equine activity program for the above named participant. The information to be released is indicated below:

- ❑ Medical History
- ❑ Physical Therapy evaluation, assessment and program plan
- ❑ Occupational Therapy evaluation, assessment and program plan
- ❑ Speech Therapy evaluation, assessment and program plan
- ❑ Mental Health diagnosis and treatment plan
- ❑ Individual Habilitation Plan (I.H.P.)
- ❑ Classroom Individual Education Plan (I.E.P.)
- ❑ Psychosocial evaluation, assessment and program plan
- ❑ Cognitive-Behavioral Management Plan
- ❑ Other: _____

This release is valid for one year and can be revoked, in writing, at my request.

Signature: _____ Date: _____

Print Name: _____

Relation to Participant: _____

Please send materials to: _____

_____

_____

_____

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Health Care Provider – Cover Letter

Date: _____

Dear Health Care Provider:

Your patient, _____
(participant's name)
is interested in participating in supervised equine activities.

In order to safely provide this service, our center requests that you complete/update the attached Medical History and Physician's Statement Form. Please note that the following conditions may suggest precautions and contraindications to equine activities. Therefore, when completing this form, please note whether these conditions are present, and to what degree.

Orthopedic
Atlantoaxial Instability - include neurologic symptoms
Coxa Arthrosis
Cranial Deficits
Heterotopic Ossification/Myositis Ossificans
Joint subluxation/dislocation
Osteoporosis
Pathologic Fractures
Spinal Joint Fusion/Fixation
Spinal Joint Instability/Abnormalities

Neurologic
Hydrocephalus/Shunt
Seizure
Spina Bifida/Chiari II malformation/Tethered Cord/Hydromyelia

Other
Age - under 4 years
Indwelling Catheters/Medical Equipment
Medications - i.e. photosensitivity
Poor Endurance
Skin Breakdown

Medical/Psychological
Allergies
Animal Abuse
Cardiac Condition
Physical/Sexual/Emotional Abuse
Blood Pressure Control
Dangerous to self or others
Exacerbations of medical conditions (i.e. RA, MS)
Fire Settings
Hemophilia
Medical Instability
Migraines
PVD
Respiratory Compromise
Recent Surgeries
Substance Abuse
Thought Control Disorders
Weight Control Disorder

Thank you very much for your assistance. If you have any questions or concerns regarding this patient's participation in equine assisted activities, please feel free to contact the center at the address/phone indicated above.

Sincerely,

Current Medical Status

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Client:_____ Age:_____
Street Address:_____City:_____ST_____ZIP_____
Parent/Guardian/Spouse:_____Phone:_____
Diagnosis:_____Date of Onset:_____

For Persons with Downs Syndrome: **Both are required**

☐ Negative Cervical X-ray for Atlantoaxial Instability. X-ray Date:_____ within past 5 years

☐ Neurological Exam has been given that specifically denies any symptoms consistent with Atlantoaxial Instability

Tetanus Shot ☐Yes ☐No Date:_____ Height:_____Weight:_____

Seizure Type_____Controlled:_____Date of last seizure:_____

Medications:_____

Indicate if patient has a problem and/or surgeries in any of the following areas by checking yes or no. If yes, please comment.

Areas	Yes	No	Comments
Auditory			
Visual			
Speech			
Cardiac			
Circulatory			
Pulmonary			
Neurological			
Muscular			
Orthopedic			
Allergies			
Learning Disabilities			
Mental Impairment			
Psychological Impairment			
Other			

Mobility- **Independent Ambulation**: ☐Yes ☐No **Crutches**: ☐Yes ☐No **Braces**: ☐Yes ☐No

Wheelchair: ☐Yes ☐No Please indicate any special precautions_____

To my knowledge there is no reason why this person cannot participate in supervised equestrian activities. However, I understand that the therapeutic riding center will weigh the medical information above against the existing precautions and contraindications. I concur with a review of this person's abilities/limitations by a licensed/credentialed health professional (e.g. PT, OT, Speech, Psychologist) in implementing of an effective equestrian program.

Physician or Health Care Provider (please print)_____
Physician or Health Care Provider (Signature):_____
Address:_____City_____ST_____ZIP_____
Phone (_____)_____Date:_____