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.
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 HORSEBACK RIDING PROGRAM INCLUDING 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 INTEND 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 VOLUNTARILY 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 ACTIVITIES, 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)
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 #: ___________________________
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: ___________________________
Participant Information Survey

Name:                      Age:                      Ht:                      Wt:                      Grade:

School/Work:               

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 ____________________________
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: ____________________________

__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
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 Arthritis
- 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
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

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.

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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:________________________