



THERAPEUTIC/ADAPTIVE RIDING REGISTRATION 2021

Hello!

THERE ARE SEVERAL CHANGES IN 2021 – PLEASE READ THIS LETTER IN IT'S ENTIRETY.

Included with this letter you will find the forms required for the participation in Autumn Trails Stable's (ATS) Therapeutic Riding program in 2021. ALL completed required forms (physician's statements, liability releases, payment agreement etc.) and payment for AT LEAST the first lesson (\$40 for group/\$50 for private) **MUST** be received by the office **NO LATER THAN 2 WEEKS PRIOR TO THE START OF THE SESSION – unless you are given another date.** (If ALL forms and/or payment are not received, the student will NOT be able to participate in that session.) Payment in advance will hold a student's place in the session, but does not guarantee a specific day or time of lesson. In addition to these forms, we will also need the Payment Agreement form as well. Our goal is to help every student have the opportunity to ride. Invoices will be sent out at the earliest possible date following receipt of all required paperwork.

IMPORTANT INFORMATION FOR 2021:

- We will continue to operate with three 8-week sessions. However, we will no longer offer a makeup week. Lesson fees are ONLY 30% of what they actually cost us to give – which is a significant discount. Weather cancellations will be made lesson by lesson verse daily as Ohio weather is so erratic. If you live a significant distance from ATS, please let us know so we can be in communication. No refunds/credits will be offered for vacations, temporary illness, or unanticipated circumstances.
- Our lesson fees have increased by \$5/lesson in order to work on bringing us up to industry standards. After five years, we feel this is a minimal increase as our supply costs have increased quite a bit. We will be offering the following discounts which CANNOT be stacked:
 - 10% sibling discount
 - 10% military discount
 - 10% Pay in Full for the Year discount
- If paying for the entire year or an entire session, we will be accepting credit card payment. However, there will be a 5% fee for using this method.

- As long as Covid-19 allows, we will be returning to GROUP lessons and they will be 45-minutes in length WITHOUT grooming or tacking for now – LONGER RIDE TIMES! We will continue taking a half hour in between lessons for thorough cleaning procedures to ensure our riders and volunteers safety. We understand some of our students may not understand the concept of social distancing and are asking parents/guardians for assistance.
- We will continue to ONLY allow ONE parent/guardian per rider during each session – NO SIBLINGS – in order to be able to properly social distance.
- EVERYONE will be REQUIRED to wear masks at this time – we understand this is not possible for some students and that is okay.
- We do ask that ALL student have their own ASTM/SEI certified helmet.
- Students with inappropriate clothing and shoes (including crocs, sandals, open-toed or open-heeled shoes), or students arriving more than 10 minutes late for activities will not be able to join their class. Fees will not be refunded/credited.
- Dogs are NOT permitted on the premises.

Please contact us at info@autumntrailsstable.com or (937) 536-9912 if you have any questions or concerns. We want every student to have the opportunity to participate so we may be able to work with you on any concerns you have. Thank you!

I have read, understand and agree to the above policies for 2021.

Adult Participant Signature _____ **Date** _____

Parent/Guardian/Caregiver _____ **Date** _____

ANNUAL PHYSICIAN’S STATEMENT MUST BE COMPLETED, SIGNED AND DATED ONLY BY THE STUDENT’S PHYSICIAN (PAGES 10-12).

Angela Stan, Executive Director
 Angel Fogle, Program Coordinator
 E-mail: info@autumntrailsstable.com
 Phone: (937) 536-9912

Mail forms to: Autumn Trails Stable
 2000 Folk Ream Road
 Springfield, Ohio 45502



THERAPEUTIC RIDING REGISTRATION 2021

Student Name _____ Age _____

Parent/Guardian _____

Address _____

City/State _____ Zip _____

Email _____

Home Phone _____ Cell Phone _____

BEST PHONE NUMBER IN CASE OF EMERGENCY OR CANCELLATION _____

In case of cancellation, please TEXT me.

PLEASE INDICATE ALL EVENTS IN WHICH STUDENT WISHES TO PARTICIPATE

SPRING SESSION (April 5th – May 29th) **SUMMER SESSION** (June 14th – August 7th)

FALL SESSION (August 30th – October 23rd)

Please list the top 3 days/time you would prefer:

Earliest time student can start class _____ Latest time student can end class _____

Please indicate what lesson format student is requesting*:

_____ Private (placement in private class is at discretion of ATS) = \$50/lesson (\$400/8-week session)

_____ 45 Minute Group (for most of our students) = \$40/lesson (\$320/8-week session)

*This is NOT guaranteed. We will accommodate all requests as best we can.

Please check here if the student will receive funding from Developmental Disabilities.

If so, please list student's SSA: _____

ATS does not directly bill third parties. ATS will assist with any required third-party paperwork at the request of the student; any fees incurred are ultimately the responsibility of the student.

Completed student registrations are processed in the order in which they are received, with priority scheduling given to those who pay in advance. Payment at the time of registration will hold a student's place in the upcoming session, but does NOT guarantee a specific day or time. We fulfill scheduling requests whenever possible.



THERAPEUTIC RIDING REGISTRATION 2021

RIDER HEALTH HISTORY

(To be updated annually)

GENERAL INFORMATION

Participant _____

Parent/Guardian _____

Address _____

County _____ Participant Occupation/School and level _____

Phone _____ Cell Phone _____

Email _____

DOB _____ Height _____ Weight _____* Gender M F

*225 lb. Weight limit variable dependent upon ambulatory status, ROM and discretion of instructor

Nationality/Race _____

HEALTH HISTORY (attach additional sheet if necessary)

Diagnosis/Disability _____

Date of Onset _____

Current therapies _____

Current Medications _____

Psycho-social function (interests, family structure, support system, etc.) _____

Past Health History _____

Recent Changes in Health History _____

Continued on next page



THERAPEUTIC RIDING REGISTRATION 2021

HEALTH HISTORY (page 2)

Precautions/Restrictions

Special assistance required (ATS may not be able to provide these, but it helps us plan classes)

YES NO

- Sign Interpretation
- Service dog assistance
- Wheelchair assist/transfer
- Visual assistance/aids
- Emotional/mental helper

Has the student had prior experience with therapeutic riding? YES NO

If so, when and where? _____

| Does the student... | Yes | No | Comments |
|--|-----|----|----------|
| Have a history of seizures? | | | |
| Follow simple directions? | | | |
| Have speech or language difficulties? | | | |
| Have communication difficulties? | | | |
| Walk independently? | | | |
| Have limited range of motion? | | | |
| Have decreased strength/ endurance? | | | |
| Have poor balance (sitting/standing)? | | | |
| Have problems with gross motor skills? | | | |
| Have problems with fine motor skills? | | | |
| Have poor balance (sitting/standing)? | | | |
| Have heart/circulation problems? | | | |
| Have digestion/elimination problems? | | | |
| Have bone/joint problems? | | | |
| Have allergies or breathing problems? | | | |
| Have emotional/behavioral problems? | | | |
| Have a fear of animals/horses? | | | |
| Have altered sensation? (specify) | | | |

Continued on next page



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HEALTH HISTORY (page 3)

IEP's

Does the student have an IEP?

No Yes

*If yes, please submit a copy of the IEP to assist ATS in creating appropriate goals.

GOALS

What would you like to accomplish in our program? (current goals at school, home, or other therapies)

ADDITIONAL COMMENTS

Please provide any additional information that you feel would be helpful in class selection and lesson planning for this participant _____

Please email any questions to info@autumntrailsstable.com

Adult Participant Signature

Date

Signature of Parent/Guardian

Date



THERAPEUTIC RIDING REGISTRATION 2021

EMERGENCY MEDICAL CONSENT/NON-CONSENT

Name _____
Last First Middle

Parent/Guardian/Caregiver _____
(if under 18) Last First Middle

Address _____ **City** _____ **Zip** _____

Phone Home _____ **Cell** _____ **Work** _____

Emergency Contact

In case of emergency notify _____ **Phone** _____
Name/Relationship

_____ **Phone** _____
Name/Relationship

Physician _____ **Phone** _____

Preferred Medical Facility _____

Describe any medical condition requiring special precautions or treatment, any medications & dosage _____

Please list all known allergies _____

Insurance Carrier _____ **Policy Number** _____

CONSENT FOR EMERGENCY MEDICAL TREATMENT

In case of medical emergency or necessity, Participant/Parent/Guardian authorizes ATS to seek or provide for Participant such medical assistance as may be necessary or advisable and further authorizes ATS to seek the assistance of any physician to medical facility to provide any medical/surgical care, including, but not limited to, hospitalization, with such treatment to include anesthesia as necessary or advisable, that the physician or medical facility deems or determines to be necessary or advisable, pending receipt by the physician or medical facility of any other consent to treatment from or on behalf of Participant. Participant/ Parent/ Guardian understands that NO LIABILITY can be accepted by any of the organizations concerned, including ATS, in the event such accident may occur. In the event any provision of this form is determined to be unenforceable, all other provisions shall remain in full force and effect.

In the event emergency medical aid/treatment is required due to illness or injury during the process of receiving services, or while being on the property of the center, I authorize Autumn Trails Stable to:

1. Secure and retain medical treatment and transportation if needed
2. Release student records upon request to the authorized individual or agency involved in the medical emergency treatment.

Adult Participant Signature _____ **Date** _____

Parent/Guardian/Caregiver _____ **Date** _____

NON-CONSENT FOR EMERGENCY MEDICAL TREATMENT

I do not give my consent for emergency medical treatment/aid in the case of illness or injury during the process of receiving services or while being on the property of the center. In the event emergency treatment/aid is required, I wish the following procedures to take place.

Non-Consent Signature _____ **Date** _____



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PHOTO RELEASE

I DO

I DO NOT

consent to and authorize the use and reproduction by ATS of any and all photographs and any audio-visual materials taken of _____ me/my son/my daughter/my ward for promotional material, educational activities, exhibitions and digital displays or for any other use for the benefit of the program. With respect to the foregoing matters, no inducements or promises have been made to secure this signature to this release other than the intention of ATS to use, or cause to be used, such photographs, films, and pictures for the primary purpose of promoting ATS and its work. ATS will strive to keep individuals' identities secure while using photos in newspapers, informational materials, website, Facebook, and other media materials.

Adult Participant Signature _____ **Date** _____

Signature of Parent/Guardian/Caregiver _____ **Date** _____

I represent to ATS that I am the parent/guardian/caregiver of the Applicant whose signature appears above. On behalf of the Applicant, I agree to and accept all of the provisions of the foregoing Photo Release. I am authorized to sign this Statement on behalf of the Applicant and my doing so legally binds the Applicant as if he or she were not a minor.

SOCIAL MEDIA POLICY

In the area of social media (print, broadcast, digital and online), the following guidelines apply in the use of social media for our participants:

1. Should you decide to create a personal blog or website, be sure to provide a clear disclaimer that the views expressed in the blog are the author's alone and do not represent the views Autumn Trails Stable
2. All information published on any participant's blog should comply with ATS' confidentiality policy. This also applies to comments posted on other social networking sites, blogs and forums.
3. Your online presence can reflect on ATS. Be aware that your comments, posts or actions captured via digital or film images can affect the image of ATS.
4. Do not use any ATS logos or trademarks without written consent.

I hereby confirm that I have read and understand the Social Media policy of Autumn Trails Stable

Adult Participant Signature _____ **Date** _____

Signature of Parent/Guardian _____ **Date** _____

I represent to ATS that I am the parent/guardian/caregiver of the Applicant whose signature appears above. On behalf of the Applicant, I agree to and accept all of the provisions of the foregoing Confidentiality Contract. I am authorized to sign this Statement on behalf of the Applicant and my doing so legally binds the Applicant as if he or she were not a minor.



THERAPEUTIC RIDING REGISTRATION 2021

Statement of Understanding, Authorization Release and Indemnity

_____ (Participant’s Name) would like to participate at Autumn Trails Stable. I acknowledge the risks and potential for risks of horseback riding. However, I feel that the possible benefits to myself/ my son/ my daughter/ my ward are greater than the risk assumed.

I hereby, intending to be legally bound, for myself, my heirs and assigns, executors or administrators waive and release forever any potential claims for damages against Autumn Trails Stable. In return for the opportunity to participate in the ATS program, I hereby forever release, acquit and discharge ATS and its officers, directors, trustees, agents, employees, representatives, volunteers, affiliates, successors and assigns (collectively the “Released and Indemnified Parties”) from any and all claims, demands and causes of action of any and every kind or nature, including those caused in whole or in part by the negligence of any of the Released and Indemnified Parties, which I may now or in the future have against any or all of the released and Indemnified Parties and that arise in whole or in part as a result of my involvement with ATS. I also understand and agree that ATS assumes no liability for accidents or acts of negligence or gross negligence by anyone, including the Released and Indemnified Parties.

I further agree to fully indemnify and defend any of the Released and Indemnified Parties against any and all claims, demands or causes of action of any and every kind or nature (including attorney’s fees and other defense costs), including those caused in whole or in part by the negligence of any or all of the Released and Indemnified Parties, which directly or indirectly relate to personal injuries or property damages sustained by me and that arise in whole or in part as a unenforceable, all other provisions shall remain in full force and effect.

Adult Participant Signature _____ **Date** _____

Signature of Parent/Guardian _____ **Date** _____

I represent to ATS that I am the parent or guardian of the Applicant whose signature appears above. I am authorized to sign this Statement on behalf of the Applicant and my doing so legally binds the Applicant as if he or she were not a minor.

OHIO STATEMENT OF INHERENT RISKS

Inherent risk of an “equine activity” means a danger or condition that is an integral part of an equine activity, including, but not limited to, any of the following:

- A. The propensity of an equine to behave in ways that may result in injury, death, or loss to persons on or around the equine;
- B. The unpredictability of an equine’s reaction to sounds, sudden movement, unfamiliar objects, persons, or other animals;
- C. Hazards, including, but not limited to, surface or subsurface conditions;
- D. Collision with another equine, another animal, a person, or an object;
- E. The potential of an equine activity participant to act in a negligent manner that may contribute to injury, death, or loss to the person of the participant or to other persons, including but not limited to, failing to maintain control over an equine or failing to act within the ability of the participant.

Adult Participant Signature _____ **Date** _____

Signature of Parent/Guardian _____ **Date** _____

I represent to ATS that I am the parent or guardian of the Applicant whose signature appears above. I am authorized to sign this Statement on behalf of the Applicant and my doing so legally binds the Applicant as if he or she were not a minor.



THERAPEUTIC RIDING REGISTRATION 2021

PHYSICIANS STATEMENT & RIDER'S MEDICAL HISTORY (PAGE 1)

(To be completed ANNUALLY)

Name _____ Date of Birth _____

Address _____

Name of Parent/Guardian _____

Diagnosis _____

Date of Onset _____

FOR PERSONS WITH DOWN SYNDROME

Neurological symptoms of Atlantoaxial Instability: Present _____ Absent _____

Tetanus Shot Yes No Date _____

Height _____ Weight _____

Seizure Type _____ Controlled _____ Date of Last Seizure _____

Seizure Warning Signs _____

Medications _____

Please 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 | | | |

Continued on next page



THERAPEUTIC RIDING REGISTRATION 2021

PHYSICIAN'S RELEASE (page 2)

INFORMATION FOR PHYSICIAN

The following conditions, if present, may represent precautions or contraindications to therapeutic horseback riding. When completing this form, please note whether these conditions are present, and to what degree.

ORTHOPEDIC

- Spinal Fusion
- Spinal Instabilities/Abnormalities
- Atlantoaxial Instabilities
- Scoliosis
- Kyphosis
- Lordosis
- Hip Subluxation and dislocation
- Osteoporosis
- Pathologic Fractures
- Coxas Arthrosis
- Heterotopic Ossification
- Osteogenesis Imperfecta
- Cranial Deficits
- Spinal Orthoses
- Internal Spinal Stabilization Devices

NEUROLOGIC

- Hydrocephalus/shunt
- Spina Bifida
- Tethered Cord
- Chiari II Malformation

MOBILITY

Independent Ambulation Yes No **Crutches** Yes No **Braces** Yes No **Wheelchair** Yes No

Please indicate any special precautions _____

Continued on next page

NEUROLOGIC (cont.)

- Hydromyelia
- Paralysis due to Spinal Cord injury
- Seizure Disorders

MEDICAL/SURGICAL

- Allergies
- Cancer
- Poor Endurance
- Recent Surgery
- Diabetes
- Peripheral Vascular Disease
- Hemophilia
- Hypertension
- Serious Heart Condition
- Stroke (Cerebrovascular Accident)

SECONDARY CONCERNS

- Behavior Problems
- Age under two years
- Age two – four years
- Acute exacerbation of chronic disorder
- Indwelling catheter



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PHYSICIAN'S RELEASE (page 3)

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, etc.) in the implementation of an effective equestrian program.

Physician name (please print)

Physician Signature

Address _____

City _____ **State** _____ **Zip** _____

Phone (____) _____ **DATE** _____