THERAPEUTIC/ADAPTIVE RIDING REGISTRATION 2022

Hello!

Included with this letter you will find the forms required for the participation in Autumn Trails Stable's (ATS) Therapeutic Riding/Adaptive riding program in 2022. 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 participant will NOT be able to participate in that session.) Payment in advance will hold a participant'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 participant have the opportunity to ride. Invoices will be sent out at the earliest possible date following receipt of all required paperwork.

IMPORTANT INFORMATION FOR 2022:

- We will continue to operate with three 8-week sessions. We will not 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.
- 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 continuing 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 participants may

not understand the concept of social distancing and are asking parents/guardians for assistance.

- NO SIBLINGS will be permitted during lessons– in order to be able to properly social distance.
- Since lessons are outdoors, we are not requiring masks for participants, volunteers, or staff. However, if you prefer, we wear masks for your participants lesson please let us know.
- We do ask that ALL participant have their own ASTM/SEI certified helmet.
- Participants with inappropriate clothing and shoes (including crocs, sandals, open-toed or open-heeled shoes), or participants 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 afogle@autumntrailsstable.org or (937) 536-9912 if you have any questions or concerns. We want every participant 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 2022.

Adult Participant Signature _____ **Date** _____
Parent/Guardian/Caregiver _____ **Date** _____

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

Angel Fogle, Program Coordinator
E-mail: afogle@autumntrailsstable.org
Phone: (937) 536-9912

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

THERAPEUTIC/ADAPTIVE RIDING REGISTRATION 2022

Participant 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 PARTICIPANT WISHES TO PARTICIPATE

☐ **SPRING SESSION** (April 4th – May 28th) ☐ **SUMMER SESSION** (June 13th – August 13th)

☐ **FALL SESSION** (September 6th – October 31st)

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

_____

Earliest time participant can start class _____ **Latest time participant can end class** _____

Please indicate what lesson format participant 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 participants) = $40/lesson ($320/8-week session)

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

☐ **Please check here if the participant will receive funding from Developmental Disabilities. You must contact your SSA to find out what funding is available prior to participant being registered.**

If so, please list participant's SSA: _____

☐ **I have confirmed with the participant's SSA that the funds are available for the above session.**

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

Completed participant 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 participant's place in the upcoming session but does NOT guarantee a specific day or time. We fulfill scheduling requests whenever possible.

THERAPEUTIC/ADAPTIVE RIDING REGISTRATION 2022

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

AUTUMN TRAILS STABLE
EQUINE-ASSISTED ACTIVITIES CENTER
Where the impossible becomes possible

THERAPEUTIC/ADAPTIVE RIDING REGISTRATION 2022

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 participant had prior experience with therapeutic/adaptive riding? YES NO

If so, when and where? _____

Does the participant…	**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

THERAPEUTIC/ADAPTIVE RIDING REGISTRATION 2022

HEALTH HISTORY (page 3)

IEP's

Does the participant 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 afogle@autumntrailsstable.org

_____ _____

Adult Participant Signature **Date**

_____ _____

Signature of Parent/Guardian **Date**

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THERAPEUTIC/ADAPTIVE RIDING REGISTRATION 2022

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 participant 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 wile 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** _____

THERAPEUTIC/ADAPTIVE RIDING REGISTRATION 2022

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 of 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/ADAPTIVE RIDING REGISTRATION 2022

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/ADAPTIVE RIDING REGISTRATION 2022

COVID-19 ACKNOWLEDGEMENT OF RISK AND ACCEPTANCE OF SERVICES

I, _____, am aware of the risks of contracting or spreading Covid-19 while working or volunteering at Autumn Trails Stable, Inc.; attending an event; and/or receiving face-to-face services from Autumn Trails Stable, Inc. during the time of a pandemic outbreak and going forward.

I am aware that face-to-face services and experiences increase my risk of contracting and passing on the Covid-19 or Coronavirus and agree to hold harmless Autumn Trails Stable, Inc. and its residents, members, officers, managers, agents, employees and all other individuals I may come in contact with during this interaction and receiving of services, providing services, attending an event or volunteering within this organization.

I agree to and will follow all guidelines for personal hygiene, personal safety and public safety as recommended by Autumn Trails Stable, Inc.; as well as my individual provider/practitioner. This may include, but is not limited to, waiting in my vehicle and/or home until I am asked to enter the building/farm; maintaining social distance; washing my hands prior to and following each session or activity; use of hand sanitizer upon request; wiping down surfaces with disinfecting wipes and/or wearing a protective medical mask and/or gloves.

I agree to stay home and/or cancel my services should I have personally exhibited or have been in contact with someone who has presented with illness within the previous 24 hours to one week, including; cough, sneezing, fever, chest congestion or additional signs of potential spread of any virus or bacteria/disease. In addition, I will follow the recommendations of my provider once I have notified them of these risks in regards to my future services or attendance during this pandemic.

Autumn Trails Stable, Inc. will engage in regular cleaning and sanitizing of the facility, horse tack, grooming supplies and office, doors, and frequently touched areas in-between clients and on a daily basis as recommended by the CDC for the safety of clients, employees, volunteers and horses.

I am signing under my own free will and agree to follow these and hold harmless all individuals associated with or through my services acquired from Autumn Trails Stable, Inc.

BY SIGNING BELOW, I CONFIRM THAT I HAVE READ AND UNDERSTAND THIS DOCUMENT.

*In the event that the undersigned is under the age of 18, the signature of a parent or guardian is required.

SIGNATURE: _____ DATE: _____

PRINTED NAME: _____

THERAPEUTIC/ADAPTIVE RIDING REGISTRATION 2022

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/ADAPTIVE RIDING REGISTRATION 2022

PHYSICIAN'S RELEASE (page 2)

INFORMATION FOR PHYSICIAN

The following conditions, if present, may represent precautions or contraindications to therapeutic/adaptive 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

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

MOBILITY

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

Please indicate any special precautions _____

_____

_____

Continued on next page

THERAPEUTIC/ADAPTIVE RIDING REGISTRATION 2022

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/adaptive 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** _____