

Following is the rider registration packet and schedule for the 2010 season.

About Our Program: High Horses offers **eight-week** sessions each spring and fall and **seven-week** sessions for summer and winter. We operate at Brookside Farm in Wilder, Vermont and have a wonderful staff of instructors and therapists along with a herd of kind, gentle horses and incredible volunteers. We offer three programs.

- Therapeutic riding is taught by our staff of certified instructors and focuses on horsemanship skills that incorporate educational, recreational, and psychosocial goals. Lessons may be private and run for one half hour, or they may be a small group of two or three riders and run for an hour.
- Our Hippotherapy Program is staffed by our therapists and focuses on equine facilitated activities that address physical, occupational, or speech/language challenges. Hippotherapy lessons are private, forty-five minute lessons.
- *Connections* is designed to incorporate a mental health component and runs for one hour.

***New Riders must attend New Rider Orientation Day.** This will be an opportunity to visit the site and meet with an instructor and/or therapist. Check below for the dates of these events and mark your calendars.

<u>Important Dates</u>	<u>Winter 1</u>	<u>Spring</u>	<u>Summer</u>	<u>Fall</u>	<u>Winter 2</u>
Application Due	Jan 4	March 8	May 3	July 5	Sept 6
New Rider Orientation	Feb 1	April 5	June 7	Aug 2	Oct 4
Lessons Begin	March 1	May 3	July 5	Aug 30	Nov 1

Our Scheduling/Wait List Guidelines: High Horses requires:

- All riders submit a completed application packet before being considered for scheduling.
- All new riders meet with an instructor or therapist at new rider orientation before being considered for scheduling.

High Horses serves as many riders as we can safely and effectively accommodate. Those that we cannot accommodate, will be placed on our wait list and will be scheduled as soon as there is an *appropriate opening*. The High Horses staff and medical consultants are happy to discuss options with the riders and/or their families, but reserve the right to make the final decision regarding scheduling.

Depending on a participant's needs and with respect to their safety and for the safety of our staff, volunteers and horses; participants may be scheduled for either private or group lessons, may ride with either a therapist or a certified instructor, or may be offered a spot in our un-mounted program.

An appropriate opening is defined as one where the needs of the rider will be safely and effectively met. Variables include the availability of staff, appropriate horse, volunteer assistants, and the rider's individual time constraints.

Lesson Policies:

- Once all riders have been mounted and class has started, latecomers will not be admitted
- Two absences without phone calls by 8am of lesson day may result in a rider being dropped from the program
- If riding lessons cannot be held due to rain or extreme heat, barn lessons will be offered instead
- High Horses will not offer make-up lessons to riders who choose not to attend their regularly scheduled lesson(s)
- If a rider is dropped from the program before the start of the fourth lesson, a pro-rated refund of the Rider's Fee will be available. After that time, refunds will not be made

Basic Rules for Participants and Visitors:

- No smoking is allowed on site
- No dogs are allowed on site
- Please walk, use appropriate voices and avoid sudden movements particularly near the horses
- Refrain from using umbrellas near the horses and riding arena
- Do not approach or feed any animals unless accompanied by a High Horses staff or volunteer who has been given explicit permission by the instructor
- Closely supervise riders, siblings of riders, and visitors while waiting in the designated waiting/observation areas
- Remain outside the riding area at all times
- Ask permission from the instructor to take photos or use a flash camera
- Wait for an instructor, or specially trained volunteer to mount or dismount the riders

A caregiver must remain on site while their rider is participating in our program. In the rare instance that a rider is excused from the ring by the instructor because of behavioral problems or because the rider is not feeling well, High Horses cannot maintain responsibility for the care of that rider.

Dress requirements:

- Closed toe and closed heel shoes
- Approved helmet (provided on site)
- Shirt

Directions to Our Site:

Brookside Farm is located on Route 5 approximately one mile south of the traffic lights in Norwich. It is on the left as you head south on Route 5, just past the Olcott Commerce Park.

Contact Information:

Administrative Office:
P.O. Box 681
Norwich, VT 05055
802-356-3386
www.highhorses.org
Director: Liz Claud
Brookside Site: 802-356-3387



Participant's Application

Participant: _____

Diagnosis: _____

DOB: _____ Age: ____ Height: _____ Weight: _____ Gender: M F

Address: _____

Phone: _____ E-mail: _____

Employer/School: _____

Parent/Legal Guardian: _____

Address (if different from above): _____

Phone (if different from above): _____

How did you hear about the program? _____

The applicant is a new rider and plans to attend the upcoming New Rider Orientation

Medications (include prescription, over-the-counter, name, dose and frequency)

Physical Function (i.e. mobility skills such as transfers, walking, wheelchair use)

Psycho/Social Function (i.e. work/school including grade completed, hobbies, relationships, family structure, support systems, companion animals, fears, etc)

Goals (i.e. Why are you applying? What would you like to accomplish?)

Signature: _____ Date: _____

PHOTO RELEASE:

I DO

I DO NOT

HORSE SHOW (September)

YES

NO

consent to and authorize the use and reproduction by High Horses Therapeutic Riding of any and all photographs and any other audio/visual materials taken of me for promotional material, educational activities, exhibitions or for any other use for the benefit of the program.

Signature: _____ Date: _____

Client, Parent or Legal Guardian



Participant's Medical History & Physician's Statement

Participant: _____ DOB: _____ Height: _____ Weight _____
 Address: _____
 Diagnosis(es) _____ Date of Onset: _____
 Past/Prospective Surgeries: _____
 Medications: _____
 Seizure Type: _____ Controlled: Y N Date of Last Seizure _____
 Shunt Present: Y N Date of last revision _____
 Special Precautions/Needs: _____

 Mobility: Independent Ambulation Y N Assisted Ambulation Y N Wheelchair Y N
 Braces/Assistive Devices: _____
 For those with Downs Syndrome: AtlantoDens Interval X-Rays, Date: _____ Result: Pos Neg
 Neurologic Symptoms of AtlantoAxial Instability: _____

Please indicate current or past special needs in the following systems/areas, including surgeries:

	Y	N	Comments
Auditory			
Visual			
Tactile Sensation			
Speech			
Cardiac			
Circulatory			
Integumentary/Skin			
Immunity			
Pulmonary			
Neurologic			
Muscular			
Balance			
Orthopedic			
Allergies			
Learning Disability			
Cognitive			
Emotional/Psychological			
Pain			
Other			

I have reviewed the list of precautions and contraindications to therapeutic horseback riding as listed on the following page. To my knowledge, there is no reason why this person cannot participate in supervised equine activities. However, I understand that High Horses will weigh the medical information above against 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, SLP, Psychologist, etc) in the implementation of an effective equine activity program.

Printed Name/Title: _____ MD DO NP PA Other _____
 Signature _____ Date: _____
 Address: _____
 Phone: _____ License/UPIN Number: _____

(continued)

In order to safely provide this service, our center requests that you complete/update the Medical History and Physician's Statement Form on the previous page. 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. Thank you.

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
Sensory Deficit
Seizure
Spina Bifida/Chiari II Malformation/Tethered Cord/Hydromyelia

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

Other:

Age-Under 4 years
Indwelling Catheters/Medical Equipment
Medications-i.e. Photosensitivity
Poor Endurance
Skin Breakdown



Liability Release

Name _____ Date of Birth _____ Today's Date _____

Address _____ City _____ State _____ Zip _____ Day Phone _____

School or Place of Employment _____ Evening Phone _____

Email address _____

In case of emergency contact: _____ Phone: _____

Emergency contact #2: _____ Phone: _____

Release:

_____ (name) would like to participate in the High Horses Therapeutic Riding Program. I acknowledge the inherent risk and potential for risks of equine activities. However, I feel that the possible benefits to me/my son/my daughter/my ward are greater than the risk assumed.

Warning:

Under Vermont Law, an equine activity sponsor is not liable for an injury to, or the death of, a participant in the equine activities resulting from the inherent risks of equine activities that are obvious and necessary, Pursuant to 12 V.S.A. 1039 – added 1995, No. 136 (ADJ. Sess.), 2. The term “Equine Activity Sponsors” includes High Horses Therapeutic Riding Program and Brookside Farm, their Board of Directors, Instructors, Therapists, Aids, Volunteers, and/or all Employees.

SIGNATURE: _____ DATE: _____

Signature of Client, Parent or Legal Guardian



Authorization for Emergency Medical Treatment

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 agency, I authorize **High Horses Therapeutic Riding Program** to:

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

Name: _____ Phone: _____ DOB: _____

Address: _____

In case of Emergency, contact: _____ Phone: _____

Physician's Name: _____ Phone : _____

Allergies to medications: _____ Current medications _____

Preferred Medical Facility: _____ Health Insurance Carrier: _____ Policy # _____

Medical conditions, medications or allergies we should know about: _____

Consent Plan (To be invoked in the event that your Emergency Contact cannot be reached.) I give consent for emergency medical treatment/aid (including x-ray, surgery, hospitalization, medication and any treatment procedure deemed "life saving" by the physician) in the event of illness or injury while on the property of High Horses.

Date : _____ Consent Signature: _____
(Client, Parent or Legal Guardian)

Non-Consent Plan 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 agency.

Parent or legal guardian will remain on site at all times during equine assisted activities
In the event emergency treatment/aid is required, I wish the following procedure to take place:

Date: _____ Non-Consent Signature: _____
(Client, Parent or Legal Guardian)



Consent For Release of Information

I hereby authorize the following people to release written and verbal information from the records of _____
(*participant's name*)

The information is to be released to High Horses Therapeutic Riding Program for the purpose of developing a therapeutic riding program for the above named participant.

(*Please fill out the name and phone number of those that apply*)

Physician (Medical History) Name: _____
Phone Number: _____

Physical Therapist Name: _____
Phone Number: _____

Occupational Therapist Name: _____
Phone Number: _____

Speech Therapist Name: _____
Phone Number: _____

Classroom Teacher Name: _____
Phone Number: _____

Counselor Name: _____
Phone Number: _____

Other Name: _____
Phone Number: _____

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

Signature _____ **Date** _____
Printed Name _____

A photocopy of this authorization shall have the same validity as the original



Physician's Prescription

*** This form is for potential hippotherapy clients only ***
(others do not need to return this form)

Client's Name: _____

Prescription, where appropriate for evaluation and treatment by a Physical, Occupational and/or Speech therapist in conjunction with the High Horses Therapeutic Riding Program.

Recommended Frequency: _____

Precautions: _____

Physician's Signature: _____ **Date:** _____

Please print, type or stamp:

Physician's Name: _____

Address: _____

Phone: _____



Scholarship Application

To be considered for a scholarship we ask that you provide the following information and that **you have exhausted all other possible funding sources**. Please call if you have any questions regarding our scholarship policy.

Please Note: All applications must be completed in full.

1. This application is for (please check one only)
Spring ___ Summer ___ Fall ___ Winter 1 ___ Winter 2 ___
2. How much are you requesting in scholarship support? \$_____ per session
(the maximum possible award is 50% of the rider's fee)
3. Have you received scholarship support from High Horses in the past? Yes___ No___
4. Annual Taxable Income \$_____ Other Income \$_____
For verification, please attach a copy of page 1 of your most recent IRS tax return
5. Number of dependants _____
6. Briefly describe any circumstances pertaining to your family and/or finances that might guide the scholarship committee in its decision making process. Please use the back of this form if needed.

Please Note! Applicants must exhaust all applicable funding sources before applying. Please do not assume that award amounts will be the same for each session. Funds for assistance are limited and may vary session to session depending on the number of applicants and their financial need. Notification of awards will be made prior to the start of each session. **Please return this application six weeks prior to the start of the session**

Rider's Name _____

Signature of Person Filling Out This Form _____ Date _____

Reminder: I have attached a copy of page 1 of my most recent IRS tax return