



# Healing Strides of VA

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[www.healingstridesofva.org](http://www.healingstridesofva.org)

## Day Release Application

**PLEASE COMPLETE THIS FORM IN ITS ENTIRETY**

Please PRINT neatly

**Participant Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

Street: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Email: \_\_\_\_\_ Home: (\_\_\_\_\_) \_\_\_\_\_ Cell: (\_\_\_\_\_) \_\_\_\_\_

Are you a Veteran and/or First Responder (please circle if applicable) Branch of Service: \_\_\_\_\_

Parents/Guardian/Spouse Name (circle one): \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_

Street (if different than above): \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

School or Institution presently attending (if applicable): \_\_\_\_\_ Grade/Year \_\_\_\_\_

**In case of an emergency, Contact:** \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_

**Contact:** \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_

### LIABILITY RELEASE

As a participant with 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 and the participant I work with are greater than the risk I assume. 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, their board of directors, instructors, therapists, aides, volunteers, employees 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 programs at Healing Strides of VA.

**Participant/Parent/Guardian/Caregiver:** \_\_\_\_\_ **Date:** \_\_\_\_\_

(Please circle one) (Signature)

### PHOTO RELEASE (Select only One option - must initial next to YES or NO)

\_\_\_\_ (Yes) I consent to and authorize the use and reproduction by Healing Strides of VA any and all photographs and any other audiovisual materials taken of me for promotional material, educational activities, exhibitions, or for any other use for the benefit of the program.

\_\_\_\_ (No) I do **not** consent to the above photo release.

**Participant/Parent/Guardian/Caregiver:** \_\_\_\_\_ **Date:** \_\_\_\_\_

(Please circle one) (Signature)

# AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

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 HSVA or activity site, 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.

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.

Physician's Name: \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_

Preferred Medical Facility: \_\_\_\_\_

Health Insurance Co\*.: \_\_\_\_\_

Policy #\*: \_\_\_\_\_ \*If readily available

List any known allergies: \_\_\_\_\_

Do you carry an inhaler? \_\_\_\_\_ (Y/N) Do you carry an EpiPen? \_\_\_\_\_ (Y/N)

Participant/Parent/Guardian/Caregiver: \_\_\_\_\_ Date: \_\_\_\_\_

(Please circle one)

(Signature)

## ACKNOWLEDGMENT OF HEALING STRIDES OF VA (HSVA) CONFIDENTIALITY POLICY

- Due to the nature of HSVA's programs, we are entrusted with sensitive personal information. Our clients are entitled to assurance of protection from unwarranted invasion of personal privacy. The Privacy Act, State and Federal Laws, regulations from licensing agencies and our basic constitutional rights are designed to protect us all from unwarranted invasion of privacy.
- No information about a client, including enrollment or residence, in written or any other form, may be disclosed to any person or organization without proper authorization. (The only exception is in a life-threatening emergency, in which necessary medical information may be disclosed to emergency personnel to expedite treatment). HSVA staff is responsible for reviewing all requests for information to ensure that the proper authorization has been obtained.
- Again, our records contain sensitive client information, which is protected by law from unauthorized disclosure. HSVA holds the moral and legal obligation to protect the interests of both our clients and employees. By signing the confidentiality agreement, I commit to protect the privacy of HSVA clients, both past and present.
- I have read the above and agree to maintain this policy during and after my tenure with HSVA. I realize that this document will become a permanent record at HSVA. I further realize that failure to comply with the policies on confidentiality could impact my involvement at HSVA.

Participant/Parent/Guardian/Caregiver: \_\_\_\_\_ Date: \_\_\_\_\_

(Please circle one)

(Signature)

Print Name of Participant: \_\_\_\_\_

HSVA Representative: \_\_\_\_\_ Date: \_\_\_\_\_

### Office Use Only

Date Entered: \_\_\_\_\_

Notes: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### Office Use Only:

Called: \_\_\_\_\_

Called: \_\_\_\_\_

Called: \_\_\_\_\_

Called: \_\_\_\_\_

Called: \_\_\_\_\_