Healing Strides of VA

PO Box 456 672 Naff Road
Boones Mill, VA 24065
P:(540)334-5825 F:(540)334-2491
www.healingstridesofva.org

Horses Inspiring Hope

Healing Strides is hosting an educational series on Facilitation Skills for Ground Based Equine Assisted Services!

Healing Strides will host four (4) opportunities for this training
Time: 10:00 AM-12:00 PM each of the following Saturday dates (please mark which date(s) you will be attending):

_____ Feb. 20
_____ March 20
_____ April 24
_____ May 15
_____ Attending All Dates

Cost is $100 for each Saturday session or $350 for all four.

Facilitator Bios:

Amanda Graham: A Licensed Clinical Mental Health Counselor who has been practicing the Eagala Model of psychotherapy and learning (EAP/EAL) for nearly 2 decades. In recent years, Amanda has been a Trainer for Eagala, and also served as Director of Education and Program Development, creating webinars and live learning experiences for people interested in certification or growing their skills in the areas of equine assisted psychotherapy and learning. Her latest venture is Unbridled Way Forward (www.unbridledwayforward.com) based in North Carolina.

Carol Young: CEO of Healing Strides of VA. An Eagala Equine Specialist since 2008, a Certified Life Coach and Leadership Coach.

Together they will present a skills-based opportunity for learning and practice.

To assure availability, you must register in advance as follows:

_____ Complete this package (Registration Form, Day Release, Covid 19 Form)
_____ Remit payment – please make checks payable to Healing Strides. If you wish to pay with a credit card, a 3% convenience fee will be added to the total. You will need to call the office if you choose to use a card.
_____ Mail all items to: Healing Strides of VA
PO Box 456
Boones Mill, VA 24065

Please call Carol with questions: 540-334-5825

HEALING STRIDES

Horses Inspiring Hope

I, _____ (Client Name), am aware of the risks of contracting Covid-19 while receiving face to face services from Healing Strides of Virginia at this time of the pandemic outbreak and the Virginia Governor Northam's declaration of a "stay at home" guideline. I am aware of the options for remote services including, telephonic and video telehealth as allowed by insurances and State Licensing Board recommendations during this pandemic outbreak. I am also aware that face to face services increase my risk of contracting and passing on the Covid-19 or Coronavirus and agree to hold harmless Healing Strides of Virginia, it's employees and all other individuals I may come in contact with during this interaction and receiving of services. I agree to and will follow all guidelines for personal hygiene, personal safety and public safety as recommended by Healing Strides of Virginia, and 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/vehicle either in person or via telephone; washing my hands prior to each session; use of hand sanitizer upon request; wiping down surfaces with disinfecting wipes and/or wearing a protective face covering and/or gloves. I agree to cancel my services should I have within the previous 24 hours to 2 weeks personally exhibited or have been in contact with someone who has presented with illness including; coughing, 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 during this pandemic. Healing Strides of Virginia will engage in regular cleaning and sanitizing of horse tack/equipement, grooming supplies and offices, doors, and frequently touched areas in-between clients and on a daily basis as recommended by the CDC and our contracted Veterinarian for the safety of clients, employees, volunteers and horses.

I am signing under my own free will and choice and agree to follow these requirements and hold harmless all individuals associated with or through my services acquired from Healing Strides of Virginia.

Client Name: _____ Date: _____

Client Signature: _____

Parent/Guardian Name: _____ Date: _____

Parent/Guardian Signature: _____

Witness Signature: _____

672 Naff Road/PO Box 456 Boones Mill, VA 24065 540/334.5825

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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: _____