Healing Strides of VA

PO Box 456 * 672 Naff Road
Boones Mill, VA 24065
P(540) 334-5825 F(540) 334-2941
www.healingstridesofva.org

Participant Application

Registration Checklist: *Make sure **all** components below are returned with the packet*

1. Information Form
2. Participant Application
3. Authorization for Emergency Medical Treatment
4. Participant Information/Medical History
5. Authorization for Release of Medical Information
6. Current Medical Status (signed by a Health Care Provider)

Information Form

Healing Strides of VA is an Educational Facility. Therapeutic Horsemanship Lessons are taught by PATH Certified Instructors and/or Instructors-In-Training. Each group lesson will last 55 minutes and the time on the equine will be *approximately 45 minutes* per lesson. All lessons will be scheduled through the Scheduling Coordinator.

Tuition: * Horsemanship/Therapeutic: $50.00 per lesson
* Private: 45 Minute $60.00 per lesson
* HSVA Horsemanship Club: See separate flyer
* Trailer In: $50.00 per group lesson or $60.00 per private lesson

- All Fees are *non-refundable*.
- Tuition will not be prorated for any circumstances.
- Full tuition is due at the beginning of each session. *(Ex: 10- week session = $500.00)*
- If you are unable to pay in full at the beginning of a session, contact our Administrative Office regarding other arrangements. If you need a Scholarship application please ask for one.
- Tuition can be mailed or placed in the lock box outside the office area. All payments (check or cash) need to be placed in an envelope with the first and last name of participant and what program/lesson you are paying for.

Make-Up Lesson Policy:

- Healing Strides of VA reserves the right to cancel, reschedule, combine or change class time due to low enrollment, weather or unforeseen circumstances. We will try our best to accommodate every rider and their parents/guardians in the event that this must occur.
- If HSVA must close due to weather or unforeseen circumstances, we will change our office message machine and our Facebook page.
- Tuition will not be prorated due to absenteeism; however, your child will be allowed to make up *one lesson* on a scheduled day and time assigned by the Scheduling Coordinator. If you cannot attend the make-up lesson, this option will be forfeited. It is your responsibility to contact the Schedule Coordinator to reschedule.
- If you choose to miss your weekly lesson for *personal reasons* you will forfeit your lesson. Tuition will not be prorated or refunded.
- In the event the participant registered decides to discontinue lessons at any time, you are required to inform Healing Strides of VA by phone or mail. No refunds will be distributed.

Please Contact HSVA for Session dates. We operate year-round.

_____(Initial) I understand that lessons may be a ground or classroom lesson (at HSVA discretion).

_____(Initial) I understand the above Fee and Make-Up Lesson Policies.

Participant/Parent/Guardian/Caregiver: ____ **Date**: _____________

(Please circle one) (Signature)

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Participant 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: ___________

Participant Information/Medical History

Please fill out entire form **or** circle* **N/A** *if not applicable

Participant Name: ________________________________ **Height:** ___________ **Weight:** _____________
School/Work: ____
Grade (if applicable): ________________

Following our mission statement: To promote wellness for people with personal challenges who can benefit from Equine Assisted Activities and Therapies in a safe and supportive environment. Please answer below:
What are your two greatest personal challenges?
1.____
____
2.____
____

Physical Limitations (if any), please tell us a bit about the participant's abilities and/or limitations: ____________
____
____**N/A**
Adaptive equipment? (please circle all that apply): **Crutches Wheelchair Walker Other** ________________

Cognitive Limitations (if any), please tell us a bit about the participant's abilities and/or limitations: _________
____
____**N/A**

Communication Style (please circle all that apply):
Verbal Non-verbal ASL Communication Device Pictures Other ___________________________

What motivates this participant? ____
____ **N/A**

Does this participant have any behaviors we need to be aware of? (physical violence, tics, melt-downs, etc.)
Please explain: ____
____ **N/A**

Does this participant have sensitivities or aversions to any specific textures, loud noises, bright lights, other? Please explain:____
____ **N/A**

What is the participant looking to gain in their experience at Healing Strides? _________________________
____

Current Therapies (Please circle all that apply): **PT OT Speech Other** ______________________________ **N/A**

Anything else you feel we may need to know? ____
____**N/A**

I authorize the release of this information to Healing Strides of VA's volunteers:

Participant/Parent/Guardian/Caregiver: ____ **Date**: _________________
(Please circle one) (Signature)

Print Name of Parent/Guardian/Caregiver: ____

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Authorization for Release of Medical Information

Participant Name: ____ **Date of Birth:** ____________________

I, the undersigned, hereby authorize ***the release and/or exchange*** of the above - named individual's health information between **Healing Strides of VA** and the person or agency listed below:

Name of Agency: ____ Name of Contact: _______________________
Street: ____ City: __________________ State: _____ Zip: ________
Email: _______________________________ Phone: (_____)________________

The purpose of this authorization is for continuity of care and/or the following:

☐Medical History
☐Physical Therapy evaluation, assessment and program plan
☐Occupational Therapy evaluation, assessment and program plan
☐Mental Health diagnosis and treatment plan
☐Individual Habilitation Plan (I.H.P.)
☐Classroom Individual Education Plan (I.E.P.)
☐Psychosocial evaluation, assessment and program plan
☐Cognitive-Behavioral Management Plan
☐Other: ____

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- I understand that the above - named individual's health information may include information relating to sexually transmitted diseases, genetics, sexual activity including contraceptive methods, AIDS/HIV where applicable. It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.
- I understand that once health information has been released, the recipient might re-disclose that disclosure and therefore HSVA has no control over it and privacy laws may no longer protect it.
- I hereby agree to indemnify and hold *Healing Strides of VA*, their employees and agents free and harmless from any actions against them for alleged invasion of privacy, libel or slander, or defamation arising from or related to disclosure of such information.
- This form must be signed by the patient if the participant is of legal age (18) or is an Emancipated Minor.
- I, do hereby, declare that I am the participant/parent/legal guardian and am responsible for the release of information with regard to the above-named participant.
- **This authorization allows Healing Strides of VA direct communication as indicated above. This authorization is valid for 2 years unless a specific expiration date is listed here:** ____________. This may be cancelled in writing at any time. A photo copy/fax of this authorization will be treated as an original. Your signature indicates that you have read and understand this form and authorize release of your information as described above. I understand that I may refuse to sign this authorization and that refusal to sign will not affect my treatment. FOR THE RECIPIENT OF THE INFORMATION: If any of the requested records contain information regarding alcohol and drug abuse treatment, it may be protected by Federal confidentiality rule (42 CFR Part 2). The Federal rules prohibit you from making any disclosure of this information unless further use of disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42CFR Part 2. A general authorization for the use or release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

______________________________ ______________________________ ______________________________
Signature of Participant *Signature of Parent or Guardian* *Date*

______________________________ ______________________________
Print Name of Participant *Print Name of Parent or Guardian*

Office Use Only
Expiration Date: ______________

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Current Medical Status

(Must be completed by a *Health Care Provider*)

Participant: ____ Age: __________ DOB: ___________________
Street Address: _______________________________City: ______________________ST_______ZIP_____________
Parent/Guardian/Spouse: ___________________________________Phone: (_______)______________________
Diagnosis: ____Date of Onset: ____________

For Persons with Downs Syndrome: (**Must be signed by Physician.)**

☐ Annual Medical Exam including a complete Neurological Exam has been given that specifically denies any symptoms consistent with Atlantoaxial Instability

***** Physicians Signature (Required): ________________________________**

Date of Examination: _____________

****Medical clearance expires 12 months from the date of examination.**

Tetanus Shot ☐Yes ☐No Date: _____________ Height: ____________Weight: ______________
Seizure Type: ________________________ Controlled: __________________Date of last seizure: ____________
Medications: ____
Indicate if patient has issues 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			

Mobility- **Independent Ambulation**: ☐Yes ☐No **Crutches**: ☐Yes ☐No **Braces**: ☐Yes ☐No

Wheelchair: ☐Yes ☐No Please indicate any special precautions: ______________________________

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, MD) in implementing of an effective equestrian program.

Physician or Health Care Provider Name (please print): ____
Physician or Health Care Provider (Signature): ____
Address: _________________________________City___________________________ST_______ZIP___________
Phone (________)_________________________**Date:**___________________________