**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

# Summer Camp 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 (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): ________________

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 Participant**: ____________________________________________

# 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

## 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:**_________________________