Horses of Hope, Inc.

"Giving Hope One Individual at a Time"

Thank you for requesting a Participant Packet.

Horses of Hope is excited to offer Equine Assisted Activities for individuals with special needs. This packet includes forms that will be helpful and necessary, so we are able to safely meet the needs of our participants. Please complete/sign all applicable forms and return to Horses of Hope at the address below.

Following is a checklist of **Required** forms, etc. to assist you:

____ Registration Form

____ Participant Questionnaire

____ Photo & Video Release

____ Waiver and Release

____ Authorization for Emergency Medical Treatment

____ Participant Policies and Procedures (Keep first 2 pages send in 3rd signature page)

____ Payment Policy

____ Participant Volunteer Survey

____ Participant's Medical History and Physician's Release (2 pages)
NOTE: THIS FORM MUST BE COMPLETED BY PHYSICIAN

The following forms are to be used if applicable to the Participant.

____ Occupational/Physical Therapy Evaluation Form (If Applicable) (2 pages)

____ Down Syndrome X-Ray Form (If Applicable)

____ New - Sponsorship Application Request (If you are requesting help with lesson fees)

When your packet is received, we will notify you to set up an appointment for an evaluation at the farm. The evaluation will allow us to determine any specific adaptive equipment and tack that may be needed. This meeting time will also give the prospective participant an opportunity to meet with the Horses of Hope staff, get acquainted with the horses, and become familiar with the layout of the farm.

We look forward to meeting with you and serving your individual needs. If you have any further questions, please feel free to contact me.

Sincerely,

Laurie Flanagan
Executive Director

Mailing Address: PO Box 94, Lock Haven, PA 17745
Farm Address: 101 Stoltzfus Lane, Mackeyville, PA
Phone: (570)726-8533 Email: horsesofhopeinc.@gmail.com www.horsesofhope.org

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2018 REGISTRATION FORM

The Horses of Hope program is located at 101 Stoltzfus Lane in Mackeyville.
After completion of this form, please mail to Horses of Hope, PO Box 94, Lock Haven, PA 17745

Participant:_____ Phone: _____

DOB:_____ Age: _____

Address: _____

Email Address of Participant or Guardian: _____

School or institution presently attending: _____

Is participant over 21, legally competent and able to sign for him/herself? _____

If participant is not over 21, not legally competent, and/or unable to sign for him/herself, a legal guardian, not the participant, must sign all of these forms.

Parent, Spouse or Guardian: _____

Relationship: _____

Address: _____

Home Phone:_____ Work Phone:_____ Cell: _____

Horses of Hope, Inc. conducts equine assisted activities several days a week. Please check the days of the week that you are available to participate and what time of the day. We will be offering three 10-week sessions in 2018. Please specify the session(s) and day(s) / time(s) that you can participate.

----- April 9 to June 15	----- June 25 to August 31	----- September 10 to November 16	
Monday	**Tuesday**	**Thursday**	**Friday**
AM_____	AM_____	AM_____	AM_____
PM_____	PM_____	PM_____	PM_____

Please list the name of the instructor, if you are requesting a specific instructor: _____

All efforts will be made to accommodate the days of the week that you are available, as well as assigning you with the Instructor of your choice. You will be contacted above available dates and riding times as soon as your packet and yearly, signed physician form is received.

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PARTICIPANT QUESTIONNAIRE

The following questionnaire is designed to give Horses of Hope, Inc. information pertaining to each individual rider's behavior and ability. This will help us prepare lesson plans and assist you in attaining individual goals. Please complete the questionnaire in as much detail as possible using the back of the page or attaching an additional sheet if necessary.

Name:_____ **Age:** _____

1. Briefly describe his/her disability:

2. What are the physical symptoms of the disability?

3. What goals do you hope he/she will achieve by participating in this program?

4. What other treatments or therapies has he/she undergone? (*Please specify when and for how long)*

5. How would you describe his/her concentration, attention span and general awareness?

6. Would you characterize him/her as happy, aggressive, easy-going, enthusiastic, passive, excitable, depressed, introverted, or extroverted?

7. How does he/she communicate? *(Expressive and Receptive language)*

8. Is there a history of incontinence?

9. What positive reinforcements does he/she respond to?

10. Please use the reverse side to indicate any other areas of the potential participant's behavior and personality that will help us to best communicate, understand and work with him/her at Horses of Hope, Inc.

Completed by *(signature)*:_____ Date: _____

Please print name and relationship to Participant:_____

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PHOTO & VIDEO RELEASE

Name of Participant:

For valuable consideration given and which is hereby acknowledged, the undersigned hereby grants to Horses of Hope, Inc. permission to take, or have taken, still and moving photographs and films of the above named Participant, and consents and authorizes Horses of Hopes, Inc., its advertising agencies, news media, and any other persons interested in Horses of Hope, Inc. and its work, to use and reproduce the photographs, films or pictures, and to circulate and publicize the same by all means, including, without limiting the generality of the foregoing, web sites, television media, brochures, pamphlets, instructional materials, books, and clinical materials.

With respect to the foregoing matters, no inducements or promises have been made to secure this signature to this release other than the intention of Horses of Hope, Inc. to use, or cause to be used, such photographs, films, and pictures for the primary purpose of promoting Horses of Hope, Inc. and its work.

I give consent:_____ Date: _____

Signature of participant, parent, or guardian *(if participant is a minor)*

I **do not** give consent:_____ Date:_____

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RELEASE: ALL VISITORS/PARTICIPANTS/VOLUNTEERS (OR PARENT OR GUARDIAN, IF UNDER 21) MUST SIGN THIS RELEASE, WAIVING LEGAL RIGHTS AGAINST **HORSES OF HOPE, INC. and KYLE and SUSAN JOHNSTON.** IF YOU DO NOT SIGN A RELEASE, YOU WILL NOT BE PERMITTED ON THE PROPERTIES.

WAIVER AND RELEASE

I,_____, a visitor to/participant of/volunteer in the Horses of Hope, Inc. equine assistance program (the "Program") or _____, the parent or legal guardian of a visitor to/participant of/volunteer in the program, am aware that all activities involving horses, including, but not limited to, riding, driving, grooming, leading, and/or any events involving horses, pose many inherent dangers, risks, and hazards. These include, but are not limited to, bodily injury and physical harm to riders, instructors, therapists, aides, groomers, leaders, handlers, side walkers, photographers, spectators, and/ or any other helpers. I freely and fully assume all dangers, risks, and hazards and the possibility of injury, death, property damage or other loss resulting from such dangers, risks, and hazards. I understand that I or my child or ward should not participate in the Program or visit the properties unless medically able. I agree to comply with Program rules and regulations, directions, instructions, and/or safety precautions given by Program employees, instructors, therapists, aides, and volunteers. My or my child's or ward's participation in the Program or visit to the properties is upon the express agreement and understanding that I have received, read, and understand this Waiver and Release.

In consideration of my or my child's or ward's participation/volunteering in the Program or visit to the properties, I hereby, for myself and any participant for whom I am a parent or legal guardian, release, discharge, hold harmless, and forever acquit Horses of Hope, Inc. together with its officers, directors, agents, representatives, employees, instructors, therapist, aides, and volunteers, and Kyle and Susan Johnston, in their individual capacities, from any and all actions, causes of action, losses, claims, or any liabilities whatsoever, including, but not limited to, illness or injury, known or unknown, now existing or which may arise in the future, which may accrue to me, my heirs, my guardians, administrators, executors, or assignees, including attorney's fees and court costs, on account of or in any way related to or arising out of my or my child's or ward's participation in the Program or visit to the properties. Finally, I assume all liability for any non-participants who accompany me.

I have had the opportunity to ask any questions that I may have and such questions have been answered to my satisfaction. I have read, understood, and agree to the above. I understand and confirm, by signing this Waiver and Release that I have given up considerable future legal rights. My signature is proof of my intention to execute a complete and unconditional Waiver and Release of all liability to the full extent of the law.

PARTICIPANT/VOLUNTEER/VISITOR'S NAME *(please print)*: _____

PARTICIPANT/VOLUNTEER/VISITOR'S SIGNATURE:_____ **Date:** _____

AGREEMENT AND CONSENT OF PARENT OR GUARDIAN OF MINOR

I, as the parent or guardian of the above visitor or participant, give my permission for my child or ward to participate in the Program or visit the properties, and further, in consideration of allowing my child or ward to participate in the program or visit the property, I agree individually and on behalf of my child or ward to the terms of the above Waiver and Release.

PARENT/GUARDIAN'S NAME *(please print)*: _____

PARENT?GUARDIAN'S SIGNATURE: _____ **Date:**_____

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AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT – PARTICIPANT

NAME_____ DOB_____ PHONE _____

ADDRESS_____ CITY/STATE _____ ZIP _____

PHYSICIAN'S NAME_____ MEDICAL FACILITY _____

HEALTH INSURANCE COMPANY_____ POLICY # _____

ALLERGIES TO MEDICATIONS OR FOODS

CURRENT MEDICATIONS

IN THE EVENT OF AN EMERGENCY, CONTACT

Name_____Relation_____ Phone #1_____ Phone #2 _____

Name_____Relation_____Phone #1_____hone #2 _____

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 Horses of Hope, Inc. to:

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

CONSENT PLAN

This authorization includes x-rays, surgery, hospitalization, medication, and any treatment procedure deemed "life saving" by the physician. This provision will only be invoked if the person(s) above is unable to be reached.

Consent Signature _____Date _____

Signature of participant, parent or guardian *(if participant is a minor)*

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. In the event emergency treatment/aid is required, I wish the following procedure to take place:

Non-Consent Signature_____Date _____

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PARTICIPANT POLICIES AND PROCEDURES

(Please keep pages 1 and 2 for your records)

Limitations

Horses of Hope, Inc. offers Equine Assisted Activities on horseback. We provide this service to adults and children. A weight limit of 225 lbs. or less for ambulatory persons has been established for horseback riding. Individuals over the weight limit can still participate in other fun, horse related activities at the farm. Most activities have some type of precautions and contraindications for participation and horse riding is no exception. Horseback riding may not be a suitable relational activity for certain individuals. Behavioral issues that may cause harm to the animals, instructors, or volunteers, or place the participant in a dangerous situation cannot be tolerated. Individuals who have severe spinal curvatures or stabilization devices that are unable to accommodate the movement of the horse, or those who lack neck and trunk control to name a few may not be suitable participants.

Clothing

Participants must wear long pants such as riding breeches, jeans or leggings to prevent chafing of legs. **Participants may not ride in shorts or skirts**. Please also avoid slick athletic pants and swishy snow pants and jackets. Participants may not ride in sandals, clogs, or slip-on shoes. Shoes or boots with a rounded toe and small heel are the safest form of footwear. Riding boots with a heel must be worn when saddles without safety stirrups are used. No dangling jewelry is permitted. Safety helmets that meet ASTM-SEI requirements are required to be worn by all participants. Helmets will be available, but it is suggested that participants acquire their own helmet. Please ask an instructor about how to determine proper fit.

Cancellation Policy

It is difficult to reschedule both horses and volunteers at short notice. If you know in advance that you have prior commitments and will be unable to attend a class, please advise us as soon as possible by calling the Instructor that normally oversees your lesson. The instructor's number will be given to you when setting up your first lesson.

Participants who are a "no-show" or cancel within two hours of the scheduled lesson time, will forfeit the lesson cost and will not receive a make-up. More than one "no-show" or late cancellation, within a ten week session, could result in loosing your appointed lesson day and time. Reinstatement of your day and time, for the next session, will be considered. Participants who arrive late for their lesson will only groom and ride for any time remaining.

Participants who must cancel remaining classes due to extreme medical situations may receive a credit for the lessons missed. This will be at the discretion of the Executive Director.

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Inclement Weather

Classes may be canceled due to bad (rain/thunder/high wind) weather. All efforts will be made to contact participant of cancellation within two hours of scheduled lesson time. For some participants and situations, an option may be that a stable management/horse care class can take place in the stables. A lesson may be canceled if the wind chill reaches 40° or below, or if the heat index reaches 90° or higher. Cancellations by Horses of Hope, Inc. instructors *will be made up.* Cancellations by Horses of Hope, Inc. because of weather *will be credited if a make-up is not possible.*

Horses of Hope, Inc. reserves the right to reschedule, cancel and amend classes and the operating calendar at any time.

Safety Rules & Code of Ethics

Your safety and well-being is our most important concern. All forms will need to be updated on an annual basis. Should the physical condition of the participant change at any time, Horses of Hope must be notified immediately, and a new Physician Release Form must be completed. (Please note that Physical Therapy and Occupational Therapy forms may not apply to each applicant).

Participants that display behaviors that are abusive and/or disruptive in manner to other participants, horses, staff, or volunteers will not be allowed to participate for the safety of everyone involved.

Please do not hand feed the horses. All treats will be given to the horses at the end of the day and at the discretion and under the supervision of the instructor.

In order to comply with PATH International standards, **only participants and volunteers will be allowed in the stable and arena area during lessons.** For the safety of our participants, please stay off the mounting ramps and out of the mounting ramp area. Parents and other spectators are asked to watch from the visitor area until students are finished with their class.

No dogs are allowed on property.

Participants must wear closed-toe shoes. If a participant arrives wearing inappropriate shoes, he/she will not be able to participate.

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It is important that participants and their families understand HoH is an amazing program run primarily by volunteers. HoH is meant to be a place where people can come and find healing and support. Negativity, gossip and rumor related talk will not be tolerated by Participants or Participant's family and could result is dismissal from the program. If you find you are dissatisfied with any aspect of the program, you should speak with your instructor, first and then the Participant Coordinator, Julie Marconi. If you need further assistance, please contact the Program Director, Vickie Hancock. We appreciate your help in making HoH the positive environment for all that come to the farm.

We strive to make this a fun, safe experience for everyone. Please do not hesitate to call the office (570) 726-8533 with any questions you may have.

I have read and understand the Policies and Procedures outlined on pages 1 and 2 concerning limitations, clothing, cancellations, inclement weather, and safety rules.

(Please return this signed page with your Participant Packet)

Participant's Name: _____ **Date:** _____

(Please print)

Signature: _____ **Date:** _____

(Participant, parent, or legal guardian over 21 and legally competent)

**There are many ways to help Horses of Hope, Inc., and we would be most appreciative of your assistance in administrative, fundraising, and even planning tasks. If interested, please contact the office.*

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POLICY

Horses of Hope is offering in 2018, three ten week session. The participant will partake in a lesson that will be 45 minutes in duration. The fee for each lesson is $35. Payments must be received prior to each lesson. There is a payment lockbox located in the community room for all payments. If you are in need of a receipt, please make a notation with payment and a receipt will be mailed to you.

____We are able to meet this payment schedule and will pay by check/money order made payable to **Horses of Hope, Inc.**

____We are requesting a Sponsorship Application at this time to request assistance with Lesson Fees.

By signing below, I agree that I have read and understand the above written payment policy.

Participant's Name:

(Please Print)

Signature:_____ Date:

(Participant, Parent, or Legal Guardian over 21 and legally competent)

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VOLUNTEER OPPORTUNITES (Participants)

Horses of Hope depends on the funds made available through a variety of events held throughout the year. These funds help us to offset some of the costs associated with our program. Participants who are unable to meet the full payment fee. will be required to participate in fundraising activities during each session, in order to continue receiving sponsorship funds. Please indicate below the fundraising events that you would like to participate in. Please check our website calendar and office bulletin boards concerning upcoming events and sales. Thank you!

_____ Walmart Donation Days

_____ Kiwanis $1 ticket sales (March, April, October, November)

_____ Sandwich / Pizza Sales

_____ Food booth at events

_____ Craft Show

_____ Open House

_____ Christmas at HoH (late November)

_____ Benefit Bingo (March & October)

_____ Restaurant promotion (HOH gets a % of proceeds)

_____ Baked goods for events

_____ Candy bars/Lollipops Sales

_____ I have a great idea for a fundraising event _____

Please provide your contact information below to be notified by text and / or emails about upcoming events.

Name: _____ Home Phone: _____

Cell Phone: _____(Text)

E-mail address:_____

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PARTICIPANT'S MEDICAL HISTORY AND PHYSICIAN'S RELEASE
MUST BE COMPLETED BY PHYSICIAN

Name _____ Date of Birth _____
Address _____
Name of Parent/Guardian _____
Diagnosis _____ Date of Onset _____
Height _____ Weight _____ Tetanus Shot Yes____ No____
Seizure Type _____ Controlled _____ Date of last seizure _____
Medications _____

_____

_____

Any contagious diseases? _____

Please indicate if patient has a problem and/or surgeries in the following areas. If yes, please comment, using the back of the form if necessary.

Areas	Yes	No	Comments
Auditory			
Visual			
Speech			
Cardiac			
Circulatory			
Pulmonary			
Neurological			
Muscular			
Orthopedic			
Allergies			
Learning Disabilities			
Mental Impairment			
Psychological Impairment			
Incontinence			
Coordination			
Balance			

Mobility: Independent Ambulation: Yes____ No____ Crutches: Yes____ No____
Wheelchair Yes____ No____ Braces: Yes____ No____

Please indicate any special precautions: _____

_____

_____

Mailing Address: PO Box 94, Lock Haven, PA 17745
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Physician Information

Contraindications to Assisted Horseback Riding

The following conditions, if present, may represent precautions and contraindications to assisted horseback riding. Please be sure to clearly identify if any of the following conditions are present and to what degree.

Orthopedic	**Yes**	**No**	**Medical/Surgical**	**Yes**	**No**
Spinal Fusion			Allergies		
Spinal Instabilities/Abnormalities			Cancer		
Atlantoaxial Instabilities			Poor Endurance		
Scoliosis			Recent Surgery		
Kyphosis			Diabetes		
Lordosis			Peripheral Vascular Disease		
Hip Subluxation and Dislocation			Varicose Veins		
Osteoporosis			Hemophilia		
Pathologic Fractures			Hypertension		
Coxas Arthrosis			Serious Heart Condition		
Heterotopic Ossification			Stroke (Cerebrovascular Accident)		
Osteogenesis Imperfecta			**Muscular**		
Cranial DeficitS			Hypotonic		
Spinal Orthoses			Hypertonic		
Internal Spinal Stabilization Devices			Trunk Control, Upper/Lower extremity, please specify		
Fractures			**Neurologic**		
			Seizure disorders		
Secondary Concerns			Hydrocephalus/shunt		
Behavior problems			Spina Bifida		
Age under two years			Tethered Cord		
Age two-four years			Chiari II Malformation		
Acute exacerbation of chronic disorder			Hydromyelia		
Indwelling catheter			Paralysis due to Spinal Cord injury		

** **If participant has Down Syndrome, an additional Atlantoaxial Dislocation X-ray form is required** **

If yes was checked for Scoliosis, Kyphosis, or Lordosis, please list the Degree and the date of last X-ray Below.

Scoliosis: Degree _____ Last X-ray Date _____

Kyphosis: Degree _____ Last X-ray Date _____

Lordosis: Degree _____ Last X-ray Date _____

To my knowledge, there is no reason why this person cannot participate in supervised equine activities. However, I understand that the PATH Intl. center will weigh the medical information above against the existing precautions and contraindications.

Printed Name _____ MD DO NP PA Other

Signature _____ Date

Address _____ City/State/Zip

Phone _____ License/UPIN Number

Further Comments/Notes: *(use back if needed)*

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