SPRING MEADOW FARM THERAPEUTIC RIDING CENTER
918 Wheelers Farms Road
Milford, CT 06461
(203) 877-4784

Spring Meadow Farm Therapeutic Riding Center, located in Milford, CT, is committed to offering the proven benefits of therapeutic riding and equine activities to physically, developmentally, and emotionally challenged children.

POLICIES AND GUIDELINES:

APPLICATION:

Upon request, Spring Meadow Farm provides the information and forms required for application. Once all forms have been completed and returned to Spring Meadow, prospective clients are assessed by staff for eligibility. We reserve the right to decide that we are unable to serve an applicant. If accepted, clients are enrolled into the program when a time slot becomes available.

ENROLLMENT:

NO ONE MAY PARTICIPATE IN SPRING MEADOW CLASSES UNTIL THE FOLLOWING MANDATORY FORMS ARE FILLED OUT, SIGNED AND DATED BY THE APPROPRIATE PARTY.

1. **Registration and Release form.**
2. **Release Emergency Medical Treatment form.**
3. **Medical History form *must* be signed and dated by a physician.**

Clients are notified of scheduled enrollment prior to the start of a session. Confirmation of intent to participate must be made to the office at that time to guarantee lesson time slot.
Spring Meadow staff is available for consultation throughout the application process and at any time during the program session. Please call with any questions, concerns, suggestions or comments: (203) 877-4784.

ATTENDANCE:

Spring Meadow expects regular attendance from all participants. There are NO refunds for missed lessons. One make up lesson is permitted and is scheduled at the end of each session.
Participants who must be absent should notify the office by calling (203) 877-4784 at least 24 hours in advance. Two absences without notification may result in a participant losing their scheduled time slot.
In the event of unforeseen circumstances such as inclement weather or teacher illness, all reasonable attempts will be made to notify clients at least two hours prior to a schedule change. In the event that a lesson must be cancelled the client will receive a make-up lesson.

FEES AND PAYMENT

All payments are due in advance of the first lesson in the form of check, cash or money order. Fees are as follows:

30 minute private lesson: 6 week series, $330.00
60 minute group lesson: 6 week series, $330.00

A non-refundable processing fee of $25 is required at the time of initial registration.

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REGISTRATION AND RELEASE FORM

Participant's Name:_____Date of Birth___/___/___Age:_____
Weight:_____Height:_____Disability:_____
School:_____Teacher's Name:_____
Primary Contact Name:_____
Check one:( )Parent ( )Guardian ( )Executor ( )Residential Mgr. ( )Other:Specify____
Mailing Address: Street:_____

City:_____

State:_____Zipcode:_____
Home Phone:_____Cell Phone:_____
E-Mail:_____
Business Name:_____Address:_____
Phone:_____E-Mail:_____

PHOTO RELEASE: _____I hereby consent to and authorize
_____I do not consent to, nor do I authorize
the use and reproduction of any and all photographs or other audiovisual materials taken of me/participant by Spring Meadow Therapeutic Riding Center for promotional printed material, educational activities, exhibitions, or for any other use for the benefit of the program.

Date:_____Signature:_____

LIABILITY RELEASE (Required): (Name) _____ would like to participate in the Spring Meadow Therapeutic Riding program. I acknowledge the risks and potential for risks of horseback riding and related equine activities, including the potential for bodily harm. However, I feel that the possible benefits for myself/my child/my ward are greater than the risk assumed. I hereby, intending to be legally bound for myself, my heirs and assigns, executors, and administrators, waive and release forever all claims for damages against Spring Meadow Therapeutic Riding Center, its Board of Directors, Instructors, Therapists, Aids, Volunteers, and/or Employees for any and all injuries and/or losses I/my child/my ward may sustain while participating in the program from whatever cause including but not limited to the negligence of these released parties.
The undersigned acknowledges that he/she has read this Registration and release form in its entirety; that he/she understands the terms of this release and has signed this release voluntarily and with full knowledge of the effects thereof.

Date:_____Signature:_____

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AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

_____Participant _____Staff _____Volunteer

Name:_____DOB:_____Phone:_____
Physician's Name:_____
Preferred Medical Facility:_____
Health Insurance Co:_____
Policy #:_____
Current Allergies, Medications, Health Concerns:_____

In the event of an emergency:
Emergency Contact 1:_____Relationship:_____
Home Phone:_____Work:_____Cell:_____

Emergency Contact 2:_____Relationship:_____
Home Phone:_____Work:_____Cell:_____

In the event that 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 SPRING MEADOW FARM THERAPEUTIC RIDING CENTER 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.**

CONSENT PLAN
This authorization includes s-ray, surgery, hospitalization, medication and any treatment procedure deemed "life saving" by the physician. This provision will only be invoked if the person(s) listed cannot be reached.
Date_____Consent Signature:_____Relationship:_____

NON-CONSENT PLAN
I do not give 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 procedures to take place.
Please give details:

Date:_____Non-Consent Signature:_____Relationship:_____

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CONSENT FOR RELEASE OF INFORMATION

I hereby authorize _____
(person or place releasing information)

To release information from the records of _____
(participant's name)

DOB:_____

This confidential information is to be released to Spring Meadow Therapeutic Riding Center for the purpose of developing an equine activity program for the above-named participant. The information to be released is marked below.

____Medical History
____Physical Therapy evaluation, assessment and program plan
____Occupational therapy evaluation, assessment and program plan
____Speech Therapy evaluation, assessment and program plan
____Psychosocial evaluation, assessment, program plan, discharge summary
____Classroom Individual Education Plan (I.E.P.)
____Cognitive-Behavioral Management Plan
____Other_____

Date:_____Signature:_____
(Client, Parent, or Legal Guardian)

Please send the indicated material to Spring Meadow Farm Therapeutic Riding Center at the address listed above. Thank you!

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Date:_____

Dear Physician,

Your patient, _____would like to participate in a therapeutic riding program which involves supervised equestrian activities.
To safely provide this service, Spring Meadow Farm requests that you complete/update the attached Medical History and Physician's Statement form. Please note that the following conditions may suggest precautions and contraindications to therapeutic horseback riding. Therefore, when completing this form, please note whether these conditions are present, and to what degree.

Orthopedic
Atlantoaxial Instability-include neurological symptoms
Coxa Arthrosis
Cranial Deficits
Heterotopic Ossification/Myositis Ossificans
Joint subluxation/dislocation
Osteoporosis
Pathologic Fractures
Spinal Fusion/Fixation
Spinal Instability/Abnormalities

Neurologic
Hydrocephalus/Shunt
Seizure
Spina BifidaDhiari II malformation/Tethered Cord/Hydromyelia

Medical/Psychological
Allergies
Animal Abuse
Physical/Sexual/Emotional Abuse
Blood Pressure Control
Dangerous to self or others
Fire Settings
Heart Conditions
Hemophilia
Migraines
Respiratory Compromise
Recent Surgery
Substance Abuse
Thought Control Disorder
Weight Control Disorder

Other
Indwelling Catheters
Medications, i.e., photosensitivity
Poor Endurance
Skin Breakdown

Thank you for your assistance. If you have any questions or concerns regarding this patient's participation in therapeutic equine activities, please feel free to contact the center at the address/phone listed above.

Sincerely,

Rhonda M. Alfano

PARTICIPANT'S MEDICAL HISTORY & PHYSICIAN'S STATEMENT

Participant:_____DOB:_____Height:_____Weight:_____
Address:_____
Diagnosis:_____Date of Onset:_____
Past/Prospective Surgeries:_____
Medications:_____
Seizure Type:_____Controlled? Y N Date of last seizure:_____
Shunt Present? Y N Date of last revision:_____
Special Precautions, Diets/Needs:_____
May participate in all activities Y N
May participate except for:_____
Mobility: Independent Ambualtion: Y N Assisted Ambulation: Y N Wheelchair:? Y N
Braces/Assistive Devices:_____
Down Syndrome participants: AtlantoDens Interval X-rays; Date:_____ Result: + -
Neurologic Symptoms of AtlantoAxial Instability:_____

This participant is up-to-date on all the following routine childhood immunizations:

Measles: Date:_____
Rubella: Date:_____
Tetanus: Date:_____
Pertussis: Date:_____
Polio: Date:_____
Diphtheria: Date:_____
Other: _____ Date:_____

Please indicate current or past difficulties in the following systems/areas, including surgeries:

Auditory:_____
Visual:_____
Tactile Sensation:_____
Speech:_____
Cardiac:_____
Circulatory:_____
Integumentary/Skin:_____
Immunity:_____
Pulmonary:_____
Neurologic:_____
Muscular:_____
Balance:_____
Orthopedic:_____
Allergies:_____
Learning Disability:_____
Cognitive:_____
Emotional/Psychological:_____
Pain:_____
Other:_____

IMPORTANT NOTE TO DOCTOR/MEDICAL FACILITY:
If you prefer to provide the requested information on your own medical form, we will accept that only when the below release section is completed, signed, dated and attached to our form.
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 referral of the patient to a licensed/credentialed health professional (e.g., PT, OT, Speech, Psychologist, etc.) in the implementations of an effective equestrian program.

Name/Title:_____MD DO Other:_____
Signature:_____Date:_____
Address:_____
Phone:_____License/UPIN Number:_____