



Heritage Christian Stables
Operated by Heritage Christian Services
 PO Box 200
 Webster, NY 14580
 585-872-2540
 Fax: 585-872-4847
www.heritagechristianstables.org

Heritage Christian Stables 2014 Riding Sessions:

Session	Session Dates	Session Length	Registration Deadline	Cost
Snow Bunny	January 6 - February 15, 2014	6 weeks	Dec. 16, 2013	\$210.00
Winter Classic	February 24 – April 19, 2014	8 weeks	January 27, 2014	\$280.00
Spring	April 28 – June 28, 2014	9 weeks	March 31, 2014	\$315.00
Summer	July 7 – August 30 , 2014	8 weeks	June 9, 2014	\$280.00
Fall	September 9 – November 30, 2014	12 weeks	August 11, 2014	\$420.00
December	TBA			

Heritage Christian Stables 2014 Horse Show Dates: June 28 and September 27, 2014

Enrollment: Participants can enroll in any number of sessions during the year. Lessons cost \$35.00 and are approximately one hour long with three or more riders, 45 minutes with two riders, one half hour with one rider. Lesson time may include grooming and tacking. The session fee is payable *in advance* of the start of the session. If a rider needs financial assistance, ask Lorrie about availability. Once the paperwork is completed, new riders may be asked to come to Heritage Christian Stables for an evaluation to determine acceptance into the program. Riders are scheduled in compatible groups according to the lesson schedule. If Heritage Christian Stables is unable to accommodate a rider that has been evaluated and accepted into the program, the rider will be placed on a waiting list until an appropriate time slot becomes available. Riders will be accommodated according to compatibility and time availability.

Attendance Policy: If Heritage Christian Stables cancels lessons, a makeup or credit will be given for the lesson. If a rider cancels, no makeup will be provided. Policy allows one pre-arranged (prior to start of lessons) credit per session. Lateness (15 minutes or more) is considered a cancellation. Any requests for exceptions to this attendance policy must be made at the time of enrollment into the session. Riders *must be accompanied* by guardian/staff while at the stables.

Clothing: Riders must wear long pants. Hard soled shoes with heels are preferred. Heritage Christian Stables has riding helmets available. Rider owned helmets must be ASTM-SEI approved for horseback riding and fit properly.

Forms: All forms must be completed prior to participation. Please keep any information pages for future reference.

Directions: Heritage Christian Stables is located at 1103 Salt Road, Webster, NY 14580.

Mailing Address: Heritage Christian Stables, PO Box 200, Webster, NY 14580



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Participant Registration

Name _____ would like to participate in the:

(Please circle one) Snow Bunny Winter Classic Spring Summer Fall 2014

Returning Riders: Took a session(s) off and now returning to ride. Please call for available lesson times.

New Riders: Have never ridden at HCS. Please call to schedule an evaluation and to schedule lessons.

Continuing Riders: Have ridden continuously with no session(s) off. Please check one below:

Can continue at same lesson time Yes _____ No _____ -we will contact you with available times.

****Lessons are scheduled on a first come, first serve basis. ****

Heritage Christian Stables will try to accommodate requests for lesson times, but in order for riders to progress in skills, it is necessary to group riders with comparable skill levels.

Address _____

City _____ State _____ Zip _____

Email _____ Best Phone # _____

Current Weight _____ Changes in Medical Condition _____

To assist in lesson cancellations at HC Stables what is the best name and number to contact:

For Heritage Riders: Payment will be billed through Heritage Christian Services

****For Community Riders:** Payment is due prior to the start of the session.**

***Please note,** if the participant cancels from the above circled session after scheduling is completed and prior to the start of the session, there is a \$50.00 cancellation fee. If the participant cancels after that session has started, the participant is responsible for full payment of the session. See Attendance Policy *

Person to contact Regarding Payment _____ email _____

Signature of person completing this form _____ Date _____

Please return to Heritage Christian Stables, PO Box 200, Webster, NY 14580 or Fax 585-872-4847.
Questions?: Lorrie Renker 585-872-2540

For Office use:
Rider level _____
Notes



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Participant's Application and Health History

GENERAL INFORMATION

Participant _____

Disability _____ Date of Onset _____

DOB _____ Age _____ Height _____ Weight _____ M F

Address _____

Street / PO Box City State Zip

Phone _____ Alternative Phone # _____

Employer / School _____ Phone # _____

Address _____

Street / PO Box City State Zip

Email Address _____

Parent / Legal Guardian _____ Phone# _____

Address (if different from above) _____

HEALTH HISTORY

Please indicate current or past problems in the following areas:

	Y	N	Comments
Vision			
Hearing			
Sensation			
Communication			
Heart			
Breathing			
Digestion			
Elimination			
Circulation			
Emotional			
Behavioral			
Pain			
Bone / Joint			
Muscular			
Thinking / Cognition			
Allergies			

Tetanus Shot Yes _____ No _____ Date _____

What medication(s) is participant currently taking, including over-the-counter medication?

Describe the participant's abilities / difficulties in the following areas (include assistance required or equipment needed.)

FUNCTION *(ie mobility skills such as transfers, walking, wheelchair use, driving / bus riding)*

SOCIAL *(ie work/school including grade completed, leisure interests, companion animals, fears/ concerns, etc.)*

GOALS *(ie reasons for participation? What does the participant want to accomplish?)*

PREVIOUS EXPERIENCE *(does the participant have any previous experience with horseback riding? If yes, please describe).*

ADDITIONAL INFORMATION:



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Participant's Team Collaboration Form

Participant's Name _____

Name of Service Coordinator _____ Phone _____ Email _____

Address _____ City _____ State _____ Zip _____

Name of Doctor _____ Phone _____ Email _____

Address _____ City _____ State _____ Zip _____

Name of Nurse _____ Phone _____ Email _____

Address _____ City _____ State _____ Zip _____

Participant receives the following collaborative services:

- | | |
|-------------------------------------|------------------------------|
| _____ Physical Therapist | _____ Recreational Therapist |
| _____ Occupational Therapist | _____ Music Therapist |
| _____ Speech and Language Therapist | _____ Art Therapist |
| _____ Psycho-therapist or Counselor | _____ Other _____ |

For all services checked above, please complete contact information: (use reverse if needed)

Service: _____ Name of provider _____ Phone _____ Email _____

Address _____ City _____ State _____ Zip _____

Service: _____ Name of provider _____ Phone _____ Email _____

Address _____ City _____ State _____ Zip _____

Service: _____ Name of provider _____ Phone _____ Email _____

Address _____ City _____ State _____ Zip _____

Service: _____ Name of provider _____ Phone _____ Email _____

Address _____ City _____ State _____ Zip _____

Service: _____ Name of provider _____ Phone _____ Email _____

Address _____ City _____ State _____ Zip _____

I give Heritage Christian Stables permission to contact the collaborative service providers listed above to obtain information that could assist the therapeutic riding instructors in providing quality services to the participant. This includes obtaining a copy of the participant's IEP or ISP. Heritage Christian Stables will keep this information confidential.

Signature of Legal Guardian: _____ Date _____



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Authorization for Emergency Medical Treatment Form

Participant Staff Volunteer

Name _____

Address _____
Street / PO Box City State Zip

Telephone _____ DOB _____

Physician's Name _____ Medical Facility _____

Health Insurance Company _____ Policy # _____

Allergies to Medications _____

Current Medications _____

In the event of an emergency, contact:

Name _____ Relation _____ Phone _____

Name _____ Relation _____ Phone _____

Name _____ Relation _____ Phone _____

In the event that emergency medical aid/treatment is required due to illness or injury during center activities, or while on the property of the agency, I authorize Heritage Christian Services/ Stables to:

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

CONSENT PLAN

This authorization includes x-ray, 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 _____
legal guardian

NON-CONSENT PLAN

I do not give my consent for emergency medical treatment/aid in the case of illness or injury during center activities or while on the property of the agency. In the event emergency treatment/aid is required, I wish the following procedures to take place:

Consent Signature _____ Date _____
legal guardian



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Liability Release and Photo Release Form

Liability Release

I/ my child would like to participate in the therapeutic horseback riding program at Heritage Christian Stables. I acknowledge the risks and potential for risks of engaging in horseback riding activities as well as activities in the close proximity to horses, however, I feel that the possible benefits to me/my child are greater than the risks assumed. I hereby, intending to be legally bound, my heirs and assigns, executors and/or administrators, waive and release forever all claims for damages against Heritage Christian Stables, a program of Heritage Christian Services, its instructors, volunteers, and/or employees for all injuries and/or losses that I/my child may sustain while participating in activities at Heritage Christian Stables.

Consent Signature _____ Date _____
(legal guardian)

Print Name and Relationship _____

PHOTO RELEASE

- I DO
 DO NOT

Consent to and authorize the use and reproduction by Heritage Christian Services, Heritage Christian Stables, and its representatives of any and all photographs and any other audiovisual materials taken of me/ my child for promotional material, educational activities, exhibitions or for any other use for the benefit of Heritage Christian Stables and Heritage Christian Services, including use on the Heritage Christian Stables Facebook page.

Signature _____ Date _____
(legal guardian)

Print Name and Relationship _____

****Medical History & Physician's Statement (To be completed by Physician)****

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Participant _____ DOB _____ Height _____ Weight _____

Street _____ City _____ State _____ Zip _____

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 / Needs _____

Mobility: Independent Ambulation Y N Assisted Ambulation Y N Wheelchair Y N

Braces / Assistive devices : _____

For those with Down Syndrome (see attached info) AtlantoDens Interval Xrays, date _____ Result + -

Neurological Symptoms of Atlanto-Axial Instability _____

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

	Y	N	Comments
Auditory			
Visual			
Tactile Sensation			
Speech			
Cardiac			
Circulatory			
Integumentary / Skin			
Immunity			
Pulmonary			
Neurological			
Muscular			
Balance			
Orthopedic			
Allergies			
Learning Disability			
Cognitive			
Emotional/psychological			
Pain			
Other			

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

Name / Title _____ MD DO NP PA Other _____

Signature _____ Date _____

Address _____

Phone _____ License/UPIN number _____ 1/11



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Information Concerning the Therapeutic Horsemanship Program

Therapeutic Horsemanship describes equine activities organized and taught by knowledgeable and skilled instructors to people with disabilities or diverse needs. Students progress in equestrian skills while improving their cognitive, physical, emotional, social, and behavioral skills.

What are the Benefits: Physically, therapeutic riding can improve coordination and help normalize muscle tone. It can help improve posture and increase the functional range of motion, muscular strength, and flexibility. Perceptual and sensory motor skills may also improve. Psychological benefits include improved motivation, self-esteem and confidence. Therapeutic riding enhances the development of cognitive skills and allows the participant to improve socialization skills and learn team work.

How do you qualify to participate in the therapeutic horsemanship program?

- Riders over the age of four
- Meets the current horse weight restrictions (200 pounds for balanced riders)
- Riders have appropriate behavior to maintain safety

The following conditions ARE contraindicated for therapeutic riding:

- Structural scoliosis greater than 30 degrees
- Uncontrolled seizures
- Positive X-Ray for Atlantoaxial Instability (see additional information)
- Tethered Cord or Chiari II Malformation
- Hip subluxation, dislocation, or degeneration
- Indwelling catheter
- Spinal Cord Injury above a T-6
- Hemophilia

The following conditions MAY BE Contraindicated:

- Osteoporosis
- Osteogenesis Imperfecta, lordosis, or kyphosis
- Recent surgeries
- Recurrent pathological fractures
- Spina Bifida
- Spinal fusions / spinal instability / spinal stabilization devices
- Varicose veins
- Diabetes

Heritage Christian Stables may be unable to accommodate a potential rider due to resources available and program capabilities (ie: horses, equipment, availability of therapist, volunteers and capabilities). Riders accepted into the program are re-evaluated on a regular basis and may become ineligible. The therapeutic riding program follows PATH's Precautions and Contraindications Guidelines.

If you have a question as to whether you qualify for the Therapeutic Horsemanship Program, contact: Heritage Christian Stables at 585-872-2540 or www.heritagechristianservices.org.



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Information Concerning Participants with Down Syndrome and Atlantoaxial Instability

Atlantoaxial Instability (AAI) has been described as instability, subluxation or dislocation of the joint between the first and second cervical vertebrae (atlantoaxial joint). Instability of the joint is generally due to poor muscle tone and joint laxity common with Down Syndrome. This is a potentially life threatening or paralyzing condition. Incidence of AAI among persons with Down Syndrome is reported to be 10 to 20 percent.

Specific radiographs, full flexion / extension X-rays of the lateral cervical spine to determine the atlanto-dens-interval measurement (ADI), are needed to rule out AAI before mounted activities are permitted. An accurate ADI measurement is not always easy to obtain and X-rays should be done by a radiologist familiar with this examination. It should be noted that X-rays done prior to the age of 2 can be less reliable, therefore, these children should not participate in mounted activities. For the child from 2-4 years, please refer to the section on Age Related Considerations, and always consult with the participant's pediatrician. A group of individuals with Down Syndrome have been reported to demonstrate neurological abnormalities with normal ADI X-rays. The cause of these abnormal neurological signs is unclear.

It is possible that the child or adult with low muscle tone, common with Down Syndrome, may suffer repeated micro-trauma to the cervical spine area. These individuals often show excessive head and neck instability.

PATH recommends that all participants with Down Syndrome have:

Prior to starting mounted activities:

- A. A medical examination with special reference to neurological function
- B. Initial lateral, or side view X-Rays, within the past 5 years, of the upper cervical region in:
 1. full flexion
 2. extension
- C. Certification by a physician that an examination did not reveal atlantoaxial instability or focal neurological disorder

With continuation of mounted activities:

- A. Annual certification from a physician that the participant's annual physical examination reveals no symptoms of AAI.
- B. Following the initial X-ray, indication for repeated X-Rays should be made at the discretion of the participant's physician.

Atlantoaxial Instability Symptoms

Change of Head Control

Torticollis
Head tilt
Stiff neck

Change in gait

Progressive clumsiness
Toe walking or scissoring
Falling
Posturing

Change in Hand Control

Progressive weakness
Fisting
Change of dominant hand
Increasing tremor

Change in Bladder Function

Change in Bowel Function

Precaution: Monitor for Neurological symptoms, report changes to the family physician.

Contraindications

- Children under the age of 2
- Neurological symptoms Atlantoaxial instability (see above)
- Positive neurological clinical signs as noted by the physician
- Significant ADI measurement as determined by the physician

**Information from the PATH Precautions and Contraindications Guidelines*