Dear Participant,

Welcome! Thank you for your interest in lessons at Heritage Christian Stables. We look forward to an exciting 2020 lesson year.

**Enrollment:** Participants can enroll in any number of sessions during the year. Lesson time may include grooming and tacking. Once the paperwork is completed we will contact you to schedule an evaluation. An evaluation helps us ensure that we can safely accommodate you in our program, recommend the proper class, develop goals and create good participant/horse/volunteer teams. Participants are scheduled in compatible groups according to the lesson schedule. If Heritage Christian Stables is unable to accommodate a participant that has been evaluated and accepted into the program, the participant will be placed on a waiting list until an appropriate time slot becomes available. Participants will be accommodated according to compatibility, time availability, and horse usage.

**Cost:** The average cost to the program to provide a lesson is $95. Through the generosity of donations and grants, we are able to offer lessons at a greatly subsidized rate. We have 6 sessions throughout the year. Our lesson fee is $40.00 for approximately a one-hour lesson with three or more participants, 45-minute lesson with two participants and one-half hour private lesson with one participant. The session fee is payable in advance of the start of the session. If a participant needs financial assistance, please request a scholarship application.

**Attendance Policy:** If Heritage Christian Stables cancels a lesson, a makeup or credit will be given for the lesson. If a participant cancels, no makeup will be provided. Policy allows one pre-arranged credit per session communicated in writing (prior to start of lessons). Lateness (15 minutes or more) is considered a cancellation. **If you cannot attend a lesson please contact Heritage Christian Stables as far in advance as possible, so that we can adjust volunteer schedules accordingly.** Any requests for exceptions to this attendance policy must be made in writing at the time of enrollment into the session. Participants must be accompanied by guardian/staff while at the stables.

**Clothing:** All participants must wear an ASTM-SEI approved helmets while participating in lessons at Heritage Christian Stables. Heritage Christian Stables has riding helmets available, though we encourage everyone to have their own if possible. Participants must wear long pants. Hard soled shoes with heels are preferred, sneakers are acceptable for non-independent riding. Crocs, flip flops, shoes that expose feet are inappropriate and unsafe which may result in ineligibility to ride. If appropriate a participant may be asked to remove dangling jewelry, tie hair back or remove jackets that are too long. Participants are to have no objects in their mouth as they can pose a choking hazard (ie: gum, hard candy, etc).

**Forms:** All forms must be completed prior to participation and are updated annually January 1st. Please keep information pages for future reference.

**Physical Address:** Heritage Christian Stables is located at 1103 Salt Road, Webster, NY 14580

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

11/19
Heritage Christian Stables 2020 Riding Sessions:

<table>
<thead>
<tr>
<th>Session</th>
<th>Session Dates</th>
<th>Session Length</th>
<th>Registration Deadline</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Snow Bunny</td>
<td>January 6 - February 15</td>
<td>6 weeks</td>
<td>Dec 16, 2019</td>
<td>$240.00</td>
</tr>
<tr>
<td>Winter Classic</td>
<td>February 24 – April 4</td>
<td>6 weeks</td>
<td>January 15, 2020</td>
<td>$240.00</td>
</tr>
<tr>
<td>Spring</td>
<td>April 13 – May 31</td>
<td>7 weeks</td>
<td>March 16, 2020</td>
<td>$280.00</td>
</tr>
<tr>
<td>Summer</td>
<td>June 8 – July 20</td>
<td>7 weeks</td>
<td>June 22, 2020</td>
<td>$280.00</td>
</tr>
<tr>
<td>Hot to Trot</td>
<td>August 3 – September 5</td>
<td>5 weeks</td>
<td>July 13, 2020</td>
<td>$200.00</td>
</tr>
<tr>
<td>Fall</td>
<td>September 14 – December 5</td>
<td>12 weeks</td>
<td>August 17, 2020</td>
<td>$480.00</td>
</tr>
<tr>
<td>December</td>
<td>TBA</td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

Heritage Christian Stables 2020 Events

Boots & Barrels: June 6, 2020
Horse Show / Volunteer & Participant Celebration: July 25, 2020
Stall Break: TBD Fall 2020

*** Please retain this page for your records***
Heritage Christian Stables  
A program of Heritage Christian Services

Participant Registration Form

Snow Bunny _____  Winter Classic _____  Spring _____  
Summer _____  Hot to Trot ___  Fall ______

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

Name ____________________________________________________________  Date of Birth _________
Address __________________________________________________________  Best Phone __________________
City __________________________ State ___________  Zip Code______________
Current Weight ________  Changes in medical conditions ________________________________

Email Address_________________________________________________________________

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

To help schedule lessons, please check ALL times you can participate. Please be accurate in regards to the time you can arrive. Checking all options does not mean that you would participate at all those times, but gives us more flexibility in scheduling. You will be contacted to confirm your time. Thank you.

<table>
<thead>
<tr>
<th>Time</th>
<th>Monday</th>
<th>Tuesday</th>
<th>Wednesday</th>
<th>Thursday</th>
<th>Friday</th>
<th>Saturday</th>
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<tbody>
<tr>
<td>10-11 am</td>
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<td>7:00-8:00</td>
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</table>

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

For Community Participants: Payment is due no later than the first lesson of the session

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

Payment will be made by:
- Self-Pay / Parent
- HCS Account
- Self Directed (Need Agreement filled out)
- Scholarship (Need application filled out)
- Other, please explain __________________________

~ Signature of person completing this form __________________________ Date__________________

Please return to Heritage Christian Stables, 1103 Salt Road (PO Box 200), Webster, NY 14580
Questions? Tara Kuba, 585.872.2540
Participant’s Application and Health History

Participant ________________________________________________________________

Disability ________________________________________________________________ Date of Onset __________

DOB ____________________ Age ___________ Height ___________ Weight ___________ M   F

* 200-pound weight limit for mounted activities variable dependent upon ambulatory status, ROM, and discretion of instructor

Address ________________________________________________________________

Phone ____________________ Street / PO Box ___________ City ___________ State ___________ Zip ___________

Alternative Phone # ____________________________________________

Employer / School ________________________________________ Phone # _______________

Address ________________________________________________________________

Phone # _______________

Address ________________________________________________________________

Email Address _______________________________________________________________________________________

Legal Guardian (ie: parent, self) _____________________________________________ Phone# _______________

Address (if different from above) _____________________________________________

** If you are your own legal guardian, do you make your own medical decisions  □ Yes  □ No

If you answered no: Whom to contact: ____________________________________________ Phone# _______________

HEALTH HISTORY

Please indicate current or past problems in the following areas:

<table>
<thead>
<tr>
<th></th>
<th>Y</th>
<th>N</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vision</td>
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<td>Hearing</td>
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<td>Sensation</td>
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<td>Communication</td>
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<td>Heart</td>
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<td>Breathing</td>
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<td>Digestion</td>
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<td>Elimination</td>
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<td>Circulation</td>
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<td>Emotional</td>
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<td>Behavioral</td>
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<td>Pain</td>
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<td>Bone / Joint</td>
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<td>Muscular</td>
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<td>Thinking / Cognition</td>
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<tr>
<td>Allergies</td>
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</tbody>
</table>

Tetanus Shot  Yes _____ No _____ Date __________________________
MANDATORY – Application incomplete unless filled in:

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

____________________________________________________________________________________
____________________________________________________________________________________

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

GENERAL BEHAVIOR CHATURESITICS:

____________________________________________________________________________________
____________________________________________________________________________________

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.)

____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

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

____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

ADDITONAL INFORMATION:

____________________________________________________________________________________
____________________________________________________________________________________

Signature __________________________________________ Date _______________

(legal guardian)

Print Name and Relationship _________________________________________________
Heritage Christian Stables
A program of Heritage Christian Services

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
_____ Occupational Therapist
_____ Speech and Language Therapist
_____ Music 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 _______

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 _______
Authorization for Emergency Medical Treatment Form

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
Heritage Christian Stables
A program of Heritage Christian Services

Liability Release and Photo Release Form

Liability Release

I/ my child would like to participate in the inclusive horsemanship 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.

I understand that I may revoke this authorization at any time by a signed, dated notice to Heritage Christian Stables. I further understand that any such revocation does not apply to the extent that persons authorized to use my information may have already acted in reliance on this authorization.

Signature _______________________________________ Date ______________

(legal guardian)

Print Name and Relationship ________________________________
**Medical History & Physician’s Statement (To be completed by Physician)**

Heritage Christian Stables

Operated by Heritage Christian Services

PO Box 200

Webster, NY 14580

585-872-2540 Fax: 585-872-4847

www.heritagechristianstables.org

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:** Neurologic Symptoms of Atlantoaxial Instability: □ Present □ Absent

Date of last Xray _______________

Please indicate current or past special needs in the following systems/areas, including surgeries. These conditions may suggest precautions and contraindications to equine activities:

<table>
<thead>
<tr>
<th>System</th>
<th>Y</th>
<th>N</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Auditory</td>
<td></td>
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<tr>
<td>Visual</td>
<td></td>
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<tr>
<td>Tactile Sensation</td>
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<tr>
<td>Speech</td>
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<tr>
<td>Cardiac</td>
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<tr>
<td>Circulatory</td>
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<td>Integumentary / Skin</td>
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<tr>
<td>Immunity</td>
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<td>Orthopedic</td>
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<td>Allergies</td>
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<tr>
<td>Learning Disability</td>
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<tr>
<td>Cognitive</td>
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<tr>
<td>Emotional/psychological</td>
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<tr>
<td>Pain</td>
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<tr>
<td>Other</td>
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</tbody>
</table>

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 __________________________________________ License/UPIN number __________________________

Phone ______________________________________________________________
Heritage Christian Stables
A program of Heritage Christian Services

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?
- Participants over the age of four
- Meets the current horse weight requirements (200 pounds for balanced participants). Participant weight is determined at the start of each session and HC Stables reserves the right to weigh participants to determine accurate horse usage.
- Participants have appropriate behavior to maintain safety

**The following conditions ARE contraindicated for therapeutic riding:**
- Structural scoliosis greater than 30 degrees
- Uncontrolled seizures
- Evidence for Atlantoaxial Instability (see additional information)
- Tethered Cord or Chiari II Malformation
- Indwelling catheter
- Spinal Cord Injury above a T-6
- Hemophilia

**The following conditions MAY BE contraindicated:**
- Hip subluxation, dislocation, or degeneration
- 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 participant due to resources available and program capabilities (ie: horses, equipment, instructors, volunteers and capabilities). Participants 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.
Heritage Christian Stables
A program of Heritage Christian Services

Information Concerning Participants with Down Syndrome and Atlantoaxial Instability

Atlantoaxial Instability (AAI) in Down Syndrome
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 ligament laxity that is common with Down syndrome, less common with other disorders. The problems that may arise with a lax joint is that there can begin to be pressure on the spinal cord, resulting in neurologic changes (see listing below). This is symptomatic AAI and will always require evaluation by an MD and restriction of high-risk activities such as riding or driving. This is a potentially paralyzing or life-threatening condition. Incidence of non-symptomatic AAI among persons with Down syndrome is reported to be 10 to 20 percent. Symptomatic AAI is much less frequently seen. For the child from two to four 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 neurologic abnormalities with no visual AAI. The cause of these abnormal neurologic signs are unclear. Neurologic signs always supercede radiographs and the presence of the neurologic disorder must be evaluated by a physician and is a contraindication for mounted equine activities.

• Note that it is not just a fall that is a potential for injury. For a participant with low muscle tone and laxity in the joints of the neck, the repeated movement of the equine or a sudden quick movement of the equine as with a spook or a misstep could be enough to cause problems. Please also see the section on Head/Neck Control.

Professional Association of Therapeutic Horsemanship International requires that all participants with Down syndrome have:

Prior to starting mounted activities:
A. A yearly medical examination including a complete neurologic exam that shows no evidence of AAI.
B. Certification by a physician that an examination did not reveal atlantoaxial instability or focal neurologic disorder.

Atlantoaxial Instability/Neurologic Symptoms

• Change of head control
  Torticollis/wry neck
  Head tilt
  Stiff neck

• Change in gait
  Progressive clumsiness
  Toe walking or scissoring
  Falling
  Posturing

* Change of hand control
  Progressive weakness
  Fisting
  Change of dominant hand
  Increasing tremor

* Change of bladder function
* Change of bowel function

Precaution:
• Monitor for neurologic symptoms. Report changes to the family/physician and discontinue until cleared by the physician.

Contraindication:
• Children under the age of two
• Neurologic symptoms of atlantoaxial instability (see listing above)
• Positive neurologic clinical signs as noted by the physician
• Significant AAI measurement as determined by the physician
• Excessive head/neck instability with or without a helmet