Heritage Christian Stables
Operated by Heritage Christian Services

Dear Participant,

Welcome! Thank you for your interest in lessons at Heritage Christian Stables. Attached you will find the mandatory paperwork that must be completed to enroll. For new riders, once we receive the paperwork, we will schedule an evaluation to ensure that we can safely accommodate you in our program, recommend the proper class, develop goals, and create good participant/horse/volunteer teams. All forms must be updated annually and returned to Heritage Christian Stables January 1st. Please keep information pages for future reference.

Mail Completed Forms to:
Heritage Christian Stables
P.O. Box 200
Webster, NY 14580
Fax to: 585-872-4847
Emailed to: stablesrider@heritagechristianstables.org

Enrollment

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 wait list until an appropriate time slot becomes available. Participants will be accommodated according to compatibility, time availability, and horse usage.

Cost

Our **lesson fee for 2023 is $45.00** for a one-hour lesson with three or more participants, a 45- minute lesson with two participants or one half-hour private lesson with one participant. The fee is payable by cash or check at the time of the lesson. If financial assistance is needed, please request a scholarship application.

Clothing & Accessories

All participants must wear an ASTM-SEI approved helmet manufactured within 5 years while participating in lessons. Heritage Christian Stables has riding helmets available, though we encourage everyone to have their own when possible. Long pants and hard soled shoes with heels are preferred for independent riders, but sneakers are acceptable for non-independent riding. Proper footwear is required at the stables; shoes that expose feet (crocs, sandals, flip flops) are unsafe and will result in ineligibility to ride. Long hair may need to be tied back and any dangling jewelry, or extra-long jackets might need to be removed.

Food

No gum or candy is allowed as they can pose a choking hazard.

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

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PARTICIPANT AVAILABILITY FORM

Name: _____ Date: _____

Returning Rider? (Please Circle) YES NO

If No, has the Participant had prior experience with horses? (Please Circle) YES NO

If so, when, and where? _____

REQUIRED: In the event of a lesson cancellation at HC Stables, who is the best person to contact?

Name: _____ Phone: _____ Can we text? _____

Please check ALL the times you can participate in a lesson. Be accurate regarding the time you can arrive. Checking all options does not mean that you would participate in all those times but gives us more flexibility in scheduling. You will be contacted to confirm your time.

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
10 AM-11 AM						
11 AM- 12 PM						
12 PM- 1 PM						
1 PM – 2 PM						
2 PM – 3 PM						
3 PM – 4 PM						
4 PM – 5 PM						
5 PM – 6 PM						
6 PM – 7 PM						
7 PM – 8 PM						

For Participants: Payment is due at time of lesson. Payment can be in the form of cash or check.

BILLING INFORMATION

Payment will be made by:

___ Self-Pay/Parent ___ HCS Account ___Self Directed (Need Agreement filled out)

___ Scholarship (Need application completed) ___ Other, please explain_____

Name: _____ Organization: _____

Address: _____
Street *City* *State* *Zip*

Home Phone: _____ Cell Phone: _____

Email: _____

Signature (of person completing form): _____

Relationship to Participant: _____

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PARTICIPANT'S APPLICATION AND HEALTH HISTORY

Today's Date: ____ /____ /____

Name: _____Preferred Name: _____ Age: _____

DOB: ____ /____ /____ Gender: M F Prefer Not to Say

Height: _____ Weight: _____lbs.

*200lb weight limit for mounted activities variable dependent on ambulatory status, ROM, and discretion of instructor

Diagnosis: _____Date of Onset: ____ /____ /____

Current Medications, including OTC: _____

_____

Address: _____

Street City State Zip

Phone: _____ Email: _____

Legal Guardian (i.e. parent, self): _____Phone: _____

Address (if different than above): _____

Street City State Zip

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

If no, Contact Name: _____Phone: _____

Current Medications, including OTC: _____

Tetanus Shot Yes_____ No _____ Date_____

HEALTH HISTORY

Does the participant…	YES	NO	Comments
Have vision/hearing difficulties?			
Have altered sensation? (specify)			
Have a fear of animals/horses?			
Have a history of seizures?			
Follow simple directions?			
Have speech or language difficulties?			
Have heart/circulation problems?			
Have breathing problems or allergies?			
Have digestion or elimination problems?			
Have emotional/behavioral problems?			
Have bone/joint problems?			
Walk independently?			
Have decreased strength/endurance?			
Have difficulties with thinking/cognition?			
Have poor balance? (sitting/standing)			
Have pain?			
Have limited range of motion?			
Have problems with fine motor skills?			
Have problems with gross motor skills?			

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PARTICIPANT'S BEHAVIORS AND GOALS

HORSEBACK RIDING AND UNMOUNTED GOALS (What does the participant want to accomplish?)

_____
_____
_____

Describe the participant's abilities/struggles in the following areas (including assistance or equipment required/needed)

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

_____
_____
_____

SOCIAL FUNCTION (work/school including grade completed, interests, family structure & supports, companion animals, fears and concerns, etc.)

_____
_____
_____

GENERAL BEHAVIOR CHARACTERISTICS

_____
_____
_____

HORSEBACK RIDING AND UNMOUNTED GOALS (What does the participant want to accomplish?)

_____
_____
_____

ADDITIONAL INFORMATION

_____
_____
_____

Signature: _____Date: _____
(Self or Legal Guardian)

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PARTICIPANT'S TEAM COLLABORATION FORM

Participant's Name: _____

Name of Service Coordinator: _____ Phone: _____
Address: _____Email: _____

Name of Doctor: _____ Phone: _____
Address: _____Email: _____

Name of Nurse: _____ Phone:_____
Address: _____Email: _____

Participant Receives the following collaborative services:

	Physical Therapy		Recreational Therapy
	Occupational Therapy		Music Therapy
	Speech & Language Therapy		Art Therapy
	Psycho-Therapy or Counseling		Other (specify)

For all services checked above, please complete contact information:

Service: ____Provider:_____ Phone:_____
Address: _____Email:_____

Service: ____Provider:_____ Phone:_____
Address: _____Email:_____

Service: ____Provider:_____ Phone:_____
Address: _____Email:_____

Service: ____Provider:_____ Phone:_____
Address: _____Email:_____

Service: ____Provider:_____ Phone:_____
Address: _____Email:_____

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. All information received by Heritage Christian Stables will be kept confidential.

Signature: _____Date: _____
Self or Legal Guardian

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AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

Name: _____DOB: _____ Pronouns:_____

Address:_____
Street *City* *State* *Zip*

Physician's Name: _____Medical Facility: _____

Health Insurance Company: _____

Allergies to Medications: _____

Caregiver Information Name: _____

Address (if different than above): _____
Street *City* *State* *Zip*

Home Phone: _____Cell Phone:_____

Name of Participant School/Employer:_____ Phone:_____

In case of emergency and caregiver is unavailable, please contact:

Name: _____Relationship: _____Phone: _____

Name: _____Relationship: _____Phone: _____

In the event of an 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: _____
Self or Legal Guardian

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MEDICAL HISTORY & PHYSICIAN'S STATEMENT

TO BE COMPLETED BY PHYSICIAN

Participant _____ DOB _____Height _____ Weight _____
Address: _____
Street *City* *State* *Zip*
Diagnosis _____ Date of Onset _____
Past / Prospective Surgeries_____
Medications_____
Seizure Present Y N 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 (Please Circle)
PRESENT ABSENT Date of Last X-Ray_____

HEALTH HISTORY

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

Does the participant…	YES	NO	Comments
Have vision/hearing difficulties?			
Have altered sensation? (specify)			
Follow simple directions?			
Have speech or language difficulties?			
Have heart/circulation problems?			
Have breathing problems or allergies?			
Have digestion or elimination problems?			
Have emotional/behavioral problems?			
Have bone/joint problems?			
Have decreased strength/endurance?			
Have difficulties with thinking/cognition?			
Have poor balance? (sitting/standing)			
Have pain?			
Have limited range of motion?			
Have problems with fine motor skills?			
Have problems with gross motor skills?			
Have skin/integumentary issues?			
Have immunity issues?			
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_____ License/UPIN Number _____
Address _____ Phone_____

Heritage Christian Stables
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January 1st, 2023

Heritage Christian Stables Cancellation Policy

To ensure the best possible service to our participants, volunteers, and staff, any schedule changes from the rider must be expressed as soon as possible. Any changes in the lesson schedule must be made in writing and presented to the riding instructor or sent in an email to stablesrider@heritagechristianstables.org at least 24 hours prior to the start of the lesson in non-emergency situations. Any participant showing up 15 or more minutes late to their scheduled lesson time will be considered a cancellation. Participants must be accompanied by guardian/staff while at stables.

Any changes after 24 hours prior to the lesson will result in the complete payment of the lesson. Continual no-shows and unexcused absences will result in the loss of the participants lesson time slot. If Heritage Christian Stables cancels a lesson, a make-up credit will be given for that change.

Please note that for self-direction participants, missed lessons cannot be billed through self-direction funds. The participant will be responsible for the missed lesson payment.

Signature (Participant or Parent/Guardian) _____

RIDER COPY – PLEASE KEEP FOR YOUR RECORDS

January 1st, 2023

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PHOTO RELEASE

☐ **I DO**

☐ **I 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, 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 _____
(Self or Legal Guardian)

Print Name and Relationship _____

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 liable in the event of exposure or contraction of such.

Consent Signature _____ Date_____
(Self or Legal Guardian)

Print Name and Relationship _____

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Information Concerning the Therapeutic and Equine Assisted Horsemanship Program

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

The Benefits of Therapeutic Horseback Riding and Equine Assisted Horsemanship

Physically, therapeutic horseback riding and assisted horsemanship can improve coordination and help normalize muscle tone. It can help improve posture and increase 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 horseback riding and equine assisted horsemanship enhances the development of cognitive skills and allows the participant to improve socialization and teamwork skills.

Qualifications to Participate in Therapeutic Horseback Riding and Equine Assisted Horsemanship

- Participants must be at least four years old
- Meets the current horse weigh requirements (200 lbs. maximum for balanced participants).
- Participants have appropriate behavior to maintain safety

The following conditions are contraindicated for Therapeutic Horseback Riding and Equine Assisted Horsemanship

- 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 for Therapeutic Horseback Riding and Equine Assisted Horsemanship

- Hip subluxation, dislocation, or degeneration
- Osteoporosis
- Osteogenesis Imperfecta, lordosis, or kyphosis
- Recent Surgeries
- Diabetes
- Recurrent pathological fractures
- Spina Bifida
- Spinal fusions, spinal instability, spinal stabilization devices
- Varicose Veins

Heritage Christian Stables may be unable to accommodate a potential participant due to resources available and program capabilities (i.e. horses, equipment, instructors, volunteers, and capabilities). Participants accepted into the program are re-evaluated on a regular basis and may become ineligible.

If you have any questions as to whether you qualify for the Therapeutic Horsemanship Program, please contact Heritage Christian Stables at 585- 872-2540 or www.heritagechristianstables.org

Information Concerning Participants with Down Syndrome and Atlantoaxial Instability

Atlantoaxial Instability (AAI) in Down Syndrome

Atlantoaxial instability (AAI) has been described as an 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 and less common with other disorders. The problems that may arise with a lax joint is that there can 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 horseback riding and 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 a child two- to four years of age, please refer to the section on Age-Related Considerations, and always consult with the participants 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 is unclear. **Neurologic signs always supersede radiographs and the presence of the neurologic disorder must be evaluated by a physician and is a contraindication for mounted equine activities.**

PLEASE NOTE: Falling is not the only 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 such as a spook or misstep could be enough to cause a problem. Please also see the section on Head/Neck Control.

Professional Association of Therapeutic Horsemanship International requires that all participants with Down Syndrome have the following 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 a physician.