Dear Veteran,

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.

Lesson Duration
The duration of the lesson is based on the number of participants. One participant will have a 30-minute lesson, 2 participants will have a 45-minute lesson, and 3+ participants will have an hour lesson.

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*
PARTICIPANT AVAILABILITY FORM

Name: ____________________________________________ Date: __________________

Has the Participant had prior experience with horses? YES NO

If you answered yes; 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.

<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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<td>10 AM-11 AM</td>
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<td>1 PM-2 PM</td>
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<td>2 PM-3 PM</td>
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<td>3 PM-4 PM</td>
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<td>4 PM-5 PM</td>
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<td>5 PM-6 PM</td>
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<td>6 PM-7 PM</td>
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<td>7 PM-8 PM</td>
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</tbody>
</table>

Signature (of person completing form): ____________________________________________

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Heritage Christian Stables
P.O. Box 200
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Emailed to: stablesrider@heritagechristianstables.org
PARTICIPANT’S BEHAVIORS AND GOALS

HORSEBACK RIDING OR 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 (interests, family structure & supports, companion animals, fears and concerns, etc.)

____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

GENERAL BEHAVIOR CHARACTERISTICS

____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

ADDITIONAL INFORMATION

____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

Signature: ________________________________  Date: ___________________

(Self or Legal Guardian)
AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

Name: ___________________________________ DOB: ___________ Pronouns: ___________

Address: ____________________________________________________________________________

<table>
<thead>
<tr>
<th>Street</th>
<th>City</th>
<th>State</th>
<th>Zip</th>
</tr>
</thead>
</table>

Physician’s Name: __________________________________________ Medical Facility: ________________

Health Insurance Company: _______________________________________________________________

Allergies to Medications: __________________________________________________________________

Current Medications & Dosages, including OTC: _______________________________________________

Caregiver Information Name: _____________________________________________________________

Address (if different than above): _________________________________________________________

<table>
<thead>
<tr>
<th>Street</th>
<th>City</th>
<th>State</th>
<th>Zip</th>
</tr>
</thead>
</table>

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: ___________

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
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
Primary Diagnosis: ___________________ Secondary Diagnosis: ___________________
Date of Onset: ____ / ____ / ____
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: ______________________
Tetanus Shot Yes_________ No ____________ Date________________

HEALTH HISTORY

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

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<tr>
<td>Have skin/integumentary issues?</td>
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<td>Have immunity issues?</td>
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<td>Other</td>
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***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
Operated by Heritage Christian Services

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 __________________________

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 __________________________________________________________
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) ____________________________

PARTICIPANT COPY – PLEASE KEEP FOR YOUR RECORDS

January 1st, 2023

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