Welcome! Thank you for your interest in lessons at Heritage Christian Stables. All forms must be completed prior to participation and updated annually January 1. Please keep this information page and the cancellation policy for your future reference.

Please return all completed forms to Heritage Christian Stables, PO Box 200, Webster, NY 14580
Or email to: stablesrider@heritagechristianstables.org
Questions? Please call us at (585) 872-2540

Enrollment: Once the paperwork is completed, 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. 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. For the health and safety of our participants, volunteers, staff and our horses, Heritage Christian Stables has a 200-pound weight limit for mounted activities variable dependent upon ambulatory status, ROM, and discretion of instructor.

Cost: Through the generosity of donations and grants, we are able to offer lessons at a subsidized rate. Our class/equine assisted therapeutic lesson fee is $50.00 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. Our self-directed class/equine assisted therapeutic lesson fee is $55.00 for one hour.

Attendance 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 in an email to stablesrider@heritagechristianstables.org or call the stables and leave a message (585) 872-2540 at least 24 hours prior to the start of the lesson in non-emergency situations. Participants must be accompanied by guardian/staff while at the stables. For full details please see the cancellation policy attached.

Clothing & Safety: All participants must wear an ASTM-SEI approved helmet manufactured within 5 years while participating in lessons at Heritage Christian Stables. Heritage Christian Stables has riding helmets available, though we encourage everyone to have their own. Participants must wear long pants and hard soled shoes with heels are preferred, sneakers are acceptable for non-independent riding. Crocs, flip flops, shoes that expose feet are 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).
Participant Availability Form

Name _________________________________ Date of Birth __________

Address ______________________________________ Street / PO Box __________ City ________ State ________ Zip __________

Phone _____________________________ Email Address _______________________________

Current Weight ________ Changes in medical conditions ______________________________________

Returning Rider? ☐ YES ☐ NO

If No, has the Participant had prior experience with horses? ☐ 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? __________

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 gives us more flexibility in scheduling. You will be contacted to confirm your time. Thank you.

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<th>Monday</th>
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<th>Wednesday</th>
<th>Thursday</th>
<th>Friday</th>
<th>Saturday</th>
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<td>10am-12pm</td>
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<td>12:00-2:00pm</td>
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<td>2:00-3:00pm</td>
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<td>7:00-8:00pm</td>
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</table>

Billing Information

Payment will be made by:
☐ Self-Pay / Parent ☐ HCS Account ☐ Self Directed (Need Agreement filled out) ~

Signature of person completing this form __________________________ Date __________
Heritage Christian Stables  
Operated by Heritage Christian Services  

Participant’s Application and Health History

Today’s Date ______________________
Participant ____________________________________________________________________
DOB ___________________ Age _____________ Height _________ Weight ________ M       F

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

Diagnosis ___________________________________________ Date of Onset __________
Current Medications, including OTC: _____________________________________________
______________________________________________________________________________
Tetanus Shot    Yes ______ No _____ Date ________________________
Address_______________________________________________________________________

Phone _____________________________________ 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>Does the participant…</th>
<th>Y</th>
<th>N</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Have vision/hearing difficulties?</td>
<td></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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<tr>
<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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<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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<tr>
<td>Walk independently?</td>
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<tr>
<td>Have decreased strength/endurance?</td>
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<tr>
<td>Have difficulties with thinking/cognition?</td>
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<tr>
<td>Have poor balance? (sitting/standing)</td>
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<tr>
<td>Have pain?</td>
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<tr>
<td>Have limited range of motion?</td>
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<tr>
<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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</tbody>
</table>
Participant’s Goals and Behavior

HORSEBACK RIDING AND UNMOUNTED GOALS (i.e. reasons for participation? What does the participant want to accomplish?)

________________________________________________________________________________________

________________________________________________________________________________________

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

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

________________________________________________________________________________________

________________________________________________________________________________________

SOCIAL FUNCTION (i.e. work/school including grade completed, leisure interests, companion animals, fears/concerns, etc.)

________________________________________________________________________________________

________________________________________________________________________________________

GENERAL BEHAVIOR CHARACTERISTICS

________________________________________________________________________________________

________________________________________________________________________________________

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 ____________________________
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:

<table>
<thead>
<tr>
<th>Physical Therapy</th>
<th>Recreational Therapy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Occupational Therapy</td>
<td>Music Therapy</td>
</tr>
<tr>
<td>Speech &amp; Language Therapy</td>
<td>Art Therapy</td>
</tr>
<tr>
<td>Psycho-Therapy or Counseling</td>
<td>Other (specify)</td>
</tr>
</tbody>
</table>

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
Authorization for Emergency Medical Treatment Form

Name ________________________________________________________________________
Address ______________________________________________________________________

Street / PO Box City State Zip
Telephone ______________________________________________ DOB _________________

Physician’s Name__________________________________ Medical Facility_______________

Caregiver’s Name _____________________________________ Phone____________________
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  
Operated by 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. In addition, I recognize that communicable disease is an inherent risk and do not hold Heritage Christian Stables liable in the event of exposure or contraction of such.

Consent Signature ___________________________ Date ________________________

(legal guardian)

Print Name and Relationship _______________________________________________________

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 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 _______________________________________________________

Equine Assisted  2024  pg. 7
Medical History & Physician’s Statement (To be completed by Physician)

Participant __________________________________________  DOB __________Height _____ Weight ______

Address _______________________________________________________________________________________
    Street / PO Box   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 x-ray _________________

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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<thead>
<tr>
<th>Does the participant…</th>
<th>Y</th>
<th>N</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
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<td>Have problems with gross motor skills?</td>
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<td>Have skin/integumentary issues?</td>
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<td>Have immunity issues?</td>
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<tr>
<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 _________________________________________________ License/UPIN number ______________________

Address _____________________________________________________________ Phone ___________________________

Signature _______________________________________________________________  Date ______________________
Information Concerning the Equine Assisted Program

**Equine Assisted Program** 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.

**The Benefits of Equine Assisted Programs**

Physically, equine 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. Equine assisted horsemanship enhances the development of cognitive skills and allows the participant to improve socialization and teamwork skills.

**Qualifications to Participate in Equine Assisted Programs**

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

**The following conditions ARE CONTRAINDICATED for Equine Assisted Programs**

- 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
- Recurrent pathological fractures
- Spina Bifida
- Spinal fusions, spinal instability, spinal stabilization devices
- Varicose Veins

**The following conditions MAY BE contraindicated for Equine Assisted Programs**

- Hip subluxation, dislocation, or degeneration
- Osteoporosis
- Osteogenesis Imperfecta, lordosis, or kyphosis
- Recent Surgeries
- Diabetes
- Tethered Cord or Chiari II Malformation
- Indwelling catheter
- Spinal Cord Injury above a T-6
- Hemophilia

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 Our Equine Assisted Programs, please contact Heritage Christian Stables at (585) 872-2540 or [www.heritagechristianstables.org](http://www.heritagechristianstables.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.

PLEASE 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 misstep or a spook 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.
January 1st, 2024

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) ___________________________________________