Albany Therapeutic Riding Center, Inc.

182 Martin Road Ext., Voorheesville, NY 12186
(518) 765-2764
albanytherapeuticridingcenter@gmail.com

Dear prospective Albany Therapeutic Riding Center, Inc. participant,

Thank you for your interest in Albany Therapeutic Riding Center, Inc.! Enclosed you will find required application paperwork, as well as some information about our program.

Albany Therapeutic Riding Center, Inc.is dedicated to helping students of all ages in gaining confidence; furthering physical, cognitive, and emotional development; and learning to build relationships with horses through therapeutic horseback riding. ATRC has provided equine assisted activities since 1981, and was the first therapeutic riding program in the Albany area. We are certified through the Professional Association of Therapeutic Horsemanship, International (PATH, Intl.) and are powered primarily by volunteers. Our facility is located at the base of the Helderberg Escarpment in the Town of New Scotland (Voorheesville), New York in a peaceful and quiet setting.

Listed below you will find an overview of our lesson fees, registration requirements and what you need to know before starting the program.

- **Weight Policy** - For the safety of our horses, riders' weight is generally limited to 185 pounds. If a rider is over 160 pounds they must be able to transfer on and off a horse without full physical support from instructors and volunteers. Decisions regarding participation will be based on availability of a suitable horse relative to the height, cognition, and balance of the participant.
- **Rates** per lesson (sessions are billed by total number of weeks in each session): $25/private lesson
- Your helmet must have a manufacture date within the last five years and meet national ASTM/SEI safety standards. Helmets older than 5 years old must be replaced according to PATH International guidelines. Please check with one of our instructors to ensure your helmet meets safety standards.
- Wearing proper attire is necessary for correct, effective and safe riding. If a student uses stirrups, they must wear specific horseback riding footwear with a low heel.
- In the event of bad weather or an instructor needs to cancel, we will contact you to reschedule.

If you have any questions regarding the enclosed forms, or if you would like to arrange a visit, please contact our instructor, Taylor, at 518-765-2764 or at albanytherapeuticridngcenter@gmail.com. We look forward to meeting you!

Sincerely,
The staff at Albany Therapeutic Riding Center, Inc.

Participant Registration Form

Participant Name _____
Address_____
City_____ Zip _____
Phone (H)_____ Phone (C)_____
Email_____
Date of Birth_____ Gender Identity _____
Age_____ Height_____ Weight_____
Diagnosis/Disability_____
Agency/Group home (if applicable)_____

Parent/ Legal Guardian (if under age 18)
Address (if different from above)_____
City_____ Zip_____ Phone _____

Individual Responsible for Scheduling and Transportation
Address (if different from above) _____
City_____ Zip _____ Phone_____
Email _____

Individual Responsible for Payment
Address (if different from above) _____
City_____ Zip _____ Phone
Email _____

How did you learn about Albany Therapeutic Riding Center, Inc.?_____
_____

Describe your previous riding experience & current level of riding
_____
_____

Describe your horseback riding goals
_____
_____

What specific physical, cognitive and/or emotional goals do you have?
_____
_____

Is there anything that would be helpful for the instructors or volunteers to know about you or your learning style?
_____
_____

Release and Waiver of Liability

My full name is:_____

My child or ward's full name (if applicable) is:_____

Child/ward's date of birth (Month/Day/Year):_____

Please check one: I would like **myself** ____ or **my child or ward** ____ (the "participant") to engage in horseback riding and/or to volunteer to aid riders who are horseback riding, which includes all activities of any nature whatsoever in conjunction with the use and enjoyment of horses, whether or not mounted, and any equipment utilized or demonstrated, all of which is defined as this "Activity."

I reside at: [Street]_____
[City/State/Zip]_____
In the event of an emergency, please contact:

1. Name: _____
    a. Relation:_____
    b. Phone:_____
2. Name: _____
    a. Relation:_____
    b. Phone:_____

In consideration for participating in this Activity, as offered by Albany Therapeutic Riding Center, Inc., I, as the Participant and in the case that the Participant is a minor or incompetent adult, as the Participant's parent (the "Parent") or legal guardian (the "Guardian) hereby, on behalf of the Participant and the Undersigned, and their respective wards, personal representatives, executors, administrators, heirs, next-of-kin, spouses and assigns, acknowledge and agree as follows:

1. Acknowledge that this Activity is a potentially dangerous activity and involves numerous obvious and non-obvious inherent risks that may cause serious injury, and in some cases, death because of the sometimes unpredictable nature and irrational behavior of horses regardless of their training and past performance;

2. Acknowledge that this Activity is instructional and not recreational and therefore does not fall within the scope of the New York General Obligations Law, § 5-326;

3. Certify that the Participant is capable of participating in this Activity and acknowledge that the undersigned Participant, Parent and/or Guardian voluntarily assumes the risk and danger of loss, injury, accident, illness, paralysis, loss of personal property, or death and expenses resulting from this Activity or the use of the horses, equipment, and gear provided to the Participant for this Activity;

4. Acknowledge and agree that the Participant who is engaged in an Albany Therapeutic Riding Center, Inc. activity will wear a safety helmet that meets or exceeds the equestrian industry standard; additionally, if the helmet is provided by the Participant, the helmet will meet the above standard;

5. Expressly WAIVE any claim, lawsuit, complaint, charge, or cause of action against Albany Therapeutic Riding Center, Inc. , its agents, therapists, board of directors, aides, employees, officers, volunteers, and affiliated organizations by the Participant, Parent and/or Guardian, as applicable, for any loss, legal liability, damages or costs whatsoever arising out of or related to any loss, injury, accident, illness, paralysis, loss of personal property, or death to the Participant, and to other persons as a result of the Participant's participation, including medical expenses, in this Activity;

6. RELEASE Albany Therapeutic Riding Center, Inc. from any claim that Albany Therapeutic Riding Center, Inc. was negligent in connection with the Participant's participation in this Activity, including but not limited to, training or selecting horses, maintenance, care, fit or adjustment of saddles or bridles, instruction on riding skills or leading and supervising riders or the use of any equipment provided by Albany Therapeutic Riding Center, Inc. or being on the premises on which Albany Therapeutic Riding Center, Inc. operates, which result in loss, damage, injury or death;

7. INDEMNIFY AND SAVE AND HOLD HARMLESS Albany Therapeutic Riding Center, Inc. from and against any loss liability, damage or cost Albany Therapeutic Riding Center, Inc. may incur arising out of or in any way connected with the Participant's handling or riding a horse and/or use of saddles, bridles, equipment, and gear provided therewith from or contributed to by the Participant's or Undersigned's own negligence; and

8. Expressly AGREE that this Release and Waiver of Liability is governed by the State of New York and is intended to be as broad and inclusive as is permitted by New York law, and that in the event any portion of this Release and Waiver of Liability is determined to be invalid, illegal, or unenforceable, the validity, legality, and enforceability of the remainder of this Release and Waiver of Liability shall continue in full legal force and effect.

I, the Undersigned, have read this Release and Waiver Agreement and understand that by signing this document, I am waiving valuable rights and/or claims that I may have against Albany Therapeutic Riding Center, Inc.

The Undersigned:
I am 18 years of age or older and am competent to contract in my own name. I have read this Release and Waiver of Liability before signing below and I fully understand its contents, meaning, and impact.

Participant
Signature:_____Date:_____
Name of Signatory (please print):_____

If Participant is age seventeen or younger, or an incompetent adult, there must be consent by a parent or guardian as follows: I hereby certify that I am the Parent or Guardian of the Participant named above and am signing below as an individual and in my capacity as the Parent or Guardian of the Participant and hereby give my consent without reservation to the foregoing on behalf of the Participant.

Signature:_____Date:_____
Parent or Legal Guardian
Name of Signatory (please print):_____

Emergency Medical Treatment Authorization Form

Name_____DOB_____Phone_____
Address_____
Physician's Name, Town, Phone_____
Health Insurance Company _____Policy #_____
Allergies to medication_____
Current medications and
dosage_____
_____

Caregiver Information: Name _____
Phone_____
Cell phone number_____
Address (if different than above)_____

In the event of an emergency, contact:
Name_____ Relationship_____ Phone_____

In the event emergency medical aid/treatment is required due to illness or injury during the process of receiving services or while being on the property of Albany Therapeutic Riding Center, Inc. , I authorize Albany Therapeutic Riding Center, Inc. to:

1. Secure and retain medical treatment and transportation if needed.
2. Release my medical, lesson 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 none of the persons listed above are unable to be reached.

Date_____ Consent Signature_____

Records Access Authorization

TO WHOM IT MAY CONCERN:

Pursuant to the regulations under HIPAA, this memorandum is authority for you to provide to Albany Therapeutic Riding Center, Inc. or their authorized representative, all medical records, psychiatric records, hospital records, x-rays, technician's reports, pharmacy or drugstore records, medical charts, offices notes, physicians reports, or other medical information related to the examination and treatment of (name of participant).

I, _____ (name of participant, parent or natural guardian), understand that the information used or disclosed may be subject to redisclosure by the person or class of persons or facility receiving it, would then no longer be protected by federal privacy regulations.

I, _____(name of participant, parent or natural guardian), may revoke this authorization by notifying Albany Therapeutic Riding Center, Inc. in writing of my desire to revoke it. However, I understand that any action already taken in reliance of this authorization cannot be reversed, and my revocation will not affect those actions. I understand that the medical provider to whom this authorization is furnished may not condition its treatment of me on whether or not I sign the authorization.

A photocopy of this authorization may be accepted with the same force and effect as an original. This authorization expires on December 31, 2018, or at such time when participant completes 2018 programming.

Dated:_____ Signature of participant/guardian_____

DOB:_____ State of New York, County: _____

On this day of , before me personally came and appeared to me known and known to be the individual described in and who executed the foregoing instrument, and who duly acknowledged to me that she/he executed the same.

Possible Reasons for Client Discharge

Please be advised of the following reasons that may lead to discharge from the program.

1. Client has reached all of his/her goals!
2. Client displays a condition listed by PATH as a contraindication to therapeutic riding.
3. Client's potential to maintain head and neck control in sitting position presents a safety concern.
4. Inability to follow directions is interfering with progress toward treatment goals.
5. Uncontrolled and inappropriate behavior that constitutes a safety risk to client, volunteer or staff.
6. Client exceeds weight limit that can safely be managed by staff, volunteers and/or horses.
7. Any change in the client's medical, physical, cognitive, or emotional condition that makes therapeutic riding or hippotherapy inappropriate.
8. Three scheduled sessions are missed without proper canceling.
9. Nonpayment of billed funds after **first (1st) lesson of each session.**

Signature of Client or Legal Guardian:_____ Date:_____

Photo Release

I, _____ consent to and authorize the use and reproduction by Albany Therapeutic Riding Center, Inc. and its representatives of any and all photographs and any other audiovisual materials taken of me and/or my child for promotional material, educational activities, exhibitions or for any other use for the benefit of Albany Therapeutic Riding Center, Inc. including use on the Albany Therapeutic Riding Center, Inc. Facebook and Instagram accounts.

Signature _____ Date _____

Print Name and Relationship to Participant_____

Confidentiality Agreement

I understand that all information (written and verbal) about participants and Albany Therapeutic Riding Center, Inc.'s program is confidential and will not be shared with anyone without the express written consent of the participant and his/her/their guardian in the case of a minor.

Signature_____Date_____

Safety Standards

- Walk while on the property
- Be gentle with animals and people
- No fighting or abusive/aggressive actions
- No throwing objects
- No fires AND no smoking
- No weapons (guns, knives, etc.), alcohol, or other illegal substances on the property
- Children must be supervised by an adult at all times
- No personal pets on the property
- Respect "Off Limits," "Authorized Personnel only," and paddock and private residence areas
- Do not enter stalls, paddocks, or pastures without first notifying a staff member.

In signing this document I, _____, agree to abide by the Safety Standards that are detailed above.

Signature: _____Date:_____

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PATH INTERNATIONAL
Professional Association of Therapeutic Horsemanship International

Mental Health Information

(To be completed by participant, parent, or guardian)

Treatment Coordinator/Therapist:_____
Organization:_____
Phone:_____
Presenting
Problems:_____
_____

Current Diagnoses:_____
Past Diagnoses:_____
Current Psychiatric Medications:_____
Please check if any of the following are present:

- ☐ Anxiety
- ☐ Depression
- ☐ ADHD
- ☐ Aggression
- ☐ Poor impulse control
- ☐ Hearing voices/other hallucinations
- ☐ History of experiencing physical, emotional, or psychological abuse
- ☐ History of committing physical, emotional, or psychological abuse
- ☐ Autism Spectrum Disorder
- ☐ Developmental Disability
- ☐ Severe mood swings
- ☐ Sensory Processing Disorder
- ☐ History of substance abuse
- ☐ Current substance abuse
- ☐ Schizophrenia-spectrum disorder
- ☐ Other mood disorder
- ☐ Dementia or Alzheimer's
- ☐ Other

Will any of the above (or anything not listed) have limitations on your participation in this program? Yes/No
If yes, please describe:
_____
_____

Briefly describe any checked boxes:_____
_____

What are some symptoms we should be aware of?_____
_____

To my knowledge, the information on *all* of the above forms is complete and accurate.
Date_____ Signature_____

Medical History & Physician's Statement

(Must be completed by physician)

Date_____

Dear Physician:_____

Your patient,_____ is interested in participating in supervised equestrian activities.
(participant's name)

In order to safely provide this service, Albany Therapeutic Riding Center, Inc. requires that you complete the attached Medical History and Physicians Statement Form. Please note that the following conditions may suggest precautions and contraindication to therapeutic horseback riding. Therefore, when completing these forms, please note whether the conditions are present and to what degree.

Weight _____Height_____ DOB _____

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_____

Date of last Hip Radiograph_____ Result (please describe)_____

Special precautions/needs _____

_____

Mobility:

- Independent Ambulation Y N
- Assisted Ambulation Y N
- Wheelchair Y N

Braces/assistive devices_____

For those with Down Syndrome:

- Atlanto Dens X-Rays, date_____ Result: + -
- Neurologic symptoms of AtlantoAxial Instability_____

_____

What physical, cognitive and/or emotional goals do you have for this participant?

_____

_____

Is the any further information that you think Albany Therapeutic Riding Center, Inc. should know regarding the medical condition of this individual?

_____

_____

_____

Patient's Name:_____

Please indicate whether these conditions are present, and to what degree. Please attach any necessary additional information.

Orthopedic

____Atlantoaxial instability-include neurologic symptoms
____Coxa Arthrosis
____Cranial Defects
____Heterotropic ossification/ Myositis Ossificans
____Joint subluxation/dislocation
____Osteoporosis
____Pathologic fractures
____Spinal fusion/fixation
____Spinal instabilities/abnormalities

Medical/Psychological

____Allergies
____Animal abuse
____Physical/ Sexual/ Emotional Abuse
____Blood pressure control
____Dangerous to self or others
____Exacerbations of medical conditions
____Fire Settings
____Heart conditions
____Hemophilia
____Medical Instability
____Migraines
____PVD
____Respiratory Compromise
____Recent surgeries
____Substance abuse
____Thought control disorder
____ Varicose veins
____Weight control disorder

Neurologic

____Hydrocephalus/shunt
____Seizure
____Spina Bifida
____Chiari II malformation
____Tethered cord
____Hydromyelia

Other

____Age-under 4 years
____Indwelling catheters
____Medications
i.e. photosensitivities
____Poor endurance
____Skin breakdown

Please indicate current or past difficulties in the following systems/arena, including surgeries:	Yes	No	Comments
Auditory			
Visual			
Tactile Sensation			
Speech			
Cardiac			
Circulatory			
Integumentary/Skin			
Immunity			
Pulmonary			
Neurologic			
Muscular			
Balance			
Orthopedic			
Allergies			
Learning Disability			
Cognitive			
Emotional/Psychological			
Pain			
Other			

After careful review of (participant's name) medical history and consideration of the risks of equestrian activities, to my knowledge, there is no reason why this person cannot participate in supervised equestrian activities.

Printed Name_____ Title_____
Signature_____ Date_____
Phone_____
Address_____
License/UPIN Number_____

Thank you very much for your assistance. If you have any questions or concerns regarding this patient's participation in therapeutic equestrian activities, please feel free to contact our instructor, Taylor Huntley via phone (518- 765-2764) or email (albanytherapeuticridingcenter@gmail.com).

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[Practitioner to fill this form out if participant is receiving services]

Dear Physical/Occupational therapist:

One of your clients is interested in therapeutic horseback riding lessons. Enclosed you will find an assessment form which will help our therapists and instructors develop a safe and effective riding program for him/her/them. Please fill out the areas that pertain to your expertise, and attach any existing assessments or reports that you feel will be helpful to our staff.

Please make special note of any precautions or contraindications to therapeutic equestrian activities.

Therapeutic riding is a unique and productive way to improve the quality of life for many children and adults with physical, cognitive or psychological challenges. Your participation in Albany Therapeutic Riding Center, Inc.'s programming is welcomed and encouraged. Please feel free to contact us if you would like more information. Thank you in advance for your assistance.

Sincerely,

Taylor Huntley
Program Coordinator
Albany Therapeutic Riding Center, Inc.

THERAPY ASSESSMENT
(Please fill out applicable areas)

Name of client:_____ Date of Birth:_____

Diagnosis:_____

History of therapy interventions:
_____
_____

Please describe the following functional abilities:

Sitting Balance (head/trunk control, balance reaction, supports needed):_____
_____

ROM Limitations: _____
_____

Active/Functional extremity movement: _____
_____

Mobility (with/without assistive devices): _____
_____

Sensory Systems:_____
_____

Equipment (when first used, purpose, present use):_____
_____

Communication methods used:_____
_____

Present primary therapy goals:_____
_____

Precautions and/or contraindications:_____
_____

Signature & Title:_____ Date: _____
Therapist's name (print):_____ Phone:_____
School, Center, Organization:_____ Phone:_____
Address_____ City_____ Zip:_____