From the Ground Up
Therapeutic Horsemanship, Inc.

1238 North Road, Tully, NY 13159

315-382-3664

contactftgu@gmail.com
www.ftguhorses.org

"engaging the power of the horse to motivate, teach & heal"

Registration Form

Participant (Rider) Name: _____

Address: _____

Home phone: _____

Alternate/cell phone: _____

Email: _____

For the safety of participants, parents/caregivers are required to accompany participants to lessons and remain on site during lessons, or to make arrangements for someone to remain on site during lessons.

Person accompanying participant: _____

Relationship to participant: _____

Address: _____

Phone: _____

Person accompanying participant: _____

Relationship to participant: _____

Address: _____

Phone: _____

Mail completed registration form to: **From the Ground Up Therapeutic Horsemanship, Inc.**
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Registration Information Sheet

(Please sign on the next page and return with Registration packet)

– **Payment Policy:** Fee for Therapeutic Riding (TR) lessons is $60 per person per lesson. For information on the fee schedule for Occupational Therapy with Horses (OTH), Equine Assisted Psychotherapy (EAP), Equine Assisted Learning (EAL) and Common Ground Natural Horsemanship (CGNH), please call the office 315-382-3664 or email ftguinfo@yahoo.com.

For TR, please remit initial payment for four lessons, or provide information on other funding (HCBS waiver, scholarship, foundation, etc.). For those riders participating in a 6, 8 or 10 session (or more) block, payment made be made in full, or payments be made monthly. **A $50 discount will be given to those who pre-pay in full for a 6, 8 or 10 (or more) session block.** No refunds will be given. Make checks payable to From the Ground Up Therapeutic Horsemanship, Inc. and mail to FTGU address above. Payment must be received prior to first lesson unless other arrangements have been made with FTGU office in advance**.**

- **Session Times/Schedule:** Generally, TR lessons run for 30 or 60 minutes, depending upon the activities and the rider. This may vary on any given day depending on the rider's tolerance and the Instructor's discretion. If a rider is unable to attend their lesson, please call at least 24 hours in advance. In the case of absence with no advance notice of cancellation (no call/no show), the lesson is forfeited. If no call/no show takes place 3 times, the rider will be discharged. If a rider is more than 15 minutes late, the session will not take place but will be eligible for a make-up lesson**. All make-up lessons will be scheduled with the Instructor.**

– **Helmet Policy:** All riders are required to wear an ASTM-SEI approved riding helmet when on or near horses (FTGU can provide a helmet). Bicycle and other helmets are not allowed except under certain medical circumstances. Please call the office for more information on alternate helmet policy.

– **Weight Limit Policy**: In order to provide safe, effective lessons for riders AND horses, FTGU has a weight limit of 200 lbs (Please be advised that not all FTGU horses can carry this weight). For participants over the weight limit, Groundwork and EAP/EAL opportunities are available.

– **Medical Clearance/Acceptance:** Participants must have paperwork completed by their physician (and caregiver if applicable) prior to participation. The paperwork should accompany the initial payment. Enrollment is on a first come/first served basis. A final determination of acceptance into the program will be made after receipt of all paperwork. We do not offer back riding, also known as tandem riding (2 persons on a horse).

–

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- **Caregiver On-Site Policy:** For safety reasons, parents and/or caregivers are required to accompany participants to lessons and remain on site during lessons, or to make arrangements for someone who is responsible for the participant to remain on site during lessons.

  Sidewalkers: All parents/caregivers and those who accompany participants to lessons are asked to attend one of From the Ground Up's regular sidewalker training sessions. If the need for additional volunteer help arises at a lesson, appropriately trained parents/caregivers will be able to help out. This will enable us to proceed with the lesson in a safe and productive manner, rather than having to cancel the lesson. A schedule for trainings will be posted on FTGU Facebook page and website ftguhorses.org

  Please note that all sidewalkers sign an Authorization for Emergency Medical Treatment form, which is provided in this Registration Packet for the designated parent/caregiver to complete for our records. Also note: Everyone assisting with lessons are asked to wear hard-toe shoes; please no sneakers or sandals.

Guest/Visitor Policy: All guests and visitors to FTGU must sign insurance waivers for both FTGU and Gentle Hill Farm. **FTGU @ Gentle Hill Farm is a smoke, alcohol & illegal substance-free environment. Children must be supervised at all times. Please leave your pets at home.**

Please sign and date below and return with Registration packet. Thank you.

Signed: **Date:**

_____ _____

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Participant's Application and Health History

(to be completed by participant or parent/legal guardian)

General Information

Participant Name: _____
DOB:_____ Age: _____ Height: _____ Weight: _____ Gender: M F
Address: _____
Phone: _____ E-mail: _____ Alternate #: _____

Employer/School:_____
Address: _____
Phone: _____

Parent/Legal Guardian: _____
Address (if different from above): _____
Phone:_____

Caregiver : _____
Phone: _____

How did you hear about the program? _____

Health History

Diagnosis: _____ Date of Onset: _____

Please indicate current or past special needs in the following areas:

	Y	N	Comments
Vision			
Hearing			
Sensation			
Communication			
Heart			
Breathing			
Digestion			
Elimination			
Circulation			
Emotional/Mental Health			
Behavioral			
Pain			
Bone/joint			
Muscular			
Thinking/Cognition			
Allergies			

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Participant's Application and Health History (cont'd)

Medications *(include prescription, over-the-counter, name, dose, and frequency)*:

_____
_____
_____
_____
_____

Describe your abilities/difficulties in the following areas (include assistance required or equipment needed):

Physical Function *(i.e. Mobility skills such as transfer, walking, wheelchair use, driving/bus riding):*

_____
_____
_____
_____
_____

Psycho/social Function *(i.e. Work/school including grade completed, leisure interests, relationships-family structure, support systems, companion animals, fears/concerns, etc.)*

_____
_____
_____
_____
_____

Goals *(i.e. Why are you applying for participation? What would you like to accomplish? Please be specific)*

_____
_____
_____
_____
_____

Signature: _____ Date: _____

~~~~~~

Photo Release: I **[ ]** DO or **[ ]** DO NOT *(check one)*

consent to and authorize the use and reproduction by From the Ground Up Therapeutic Horsemanship, Inc. of any and all photographs and any other audio/visual materials taken of me for promotional material, educational activities, exhibitions or for any other use for the benefit of the program.

Signature: _____ Date: _____
(Participant, Parent or legal Guardian, signed in the presence of center staff)
~~~~~~

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Participant's Consent for Release of Information

I hereby authorize: _____ to release information
(person or facility)

from the records of: _____ DOB:_____
(participant's name)

The information is to be released to: _____
(FTGU or Director's name)

for the purposes of developing an equine activity program for the above named participant. Any of the information listed below that you can provide is greatly appreciated :

- Medical History
- Physical Therapy evaluation, assessment and program plan
- Occupational Therapy evaluation, assessment and program plan
- Speech Therapy evaluation, assessment and program plan
- Mental Health diagnosis and treatment plan
- Individual Habilitation Plan (I.H.P.)
- Classroom Individual Education Plan (I.E.P.)
- Psychosocial evaluation, assessment and program plan
- Cognitive-Behavioral Management Plan
- Other:
  _____

This release is valid for one year and can be revoked, in writing, at my request.

Signature: _____ Date:_____

Print Name: _____

Relation to Participant: _____

Please send materials to: **Andrea Colella, Program Director**
From the Ground Up Therapeutic Horsemanship, Inc.
1238 North Road, Tully, NY 13159

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Date:

Dear Physician:

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

In order to safely provide this service, From the Ground Up Therapeutic Horsemanship, Inc. requests that you complete the attached Medical History and Physician's Statement Form. Please note that the following conditions may suggest precautions and contraindications to therapeutic horseback riding. Therefore, when completing this form, please note whether these conditions are present, and to what degree.

Orthopedic
Atlantoaxial Instability – including neurologic symptoms
Coxa Arthrosis
Cranial Deficits
Heterotopic Ossification/Myositis Ossificans
Joint subluxation/dislocation
Osteoporosis
Pathologic Fractures
Spinal Fusion/Fixation
Spinal Instability/Abnormalities

Neurologic
Hydrocephalus/Shunt
Seizure
Spina Bifida/Chiari II malformation/Tethered Cord/Hydromyelia

Other
Age – under 4
Indwelling Catheters
Medications – i.e. photosensitivity
Poor Endurance
Skin Breakdown

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 Disorders
Weight Control Disorders

Thank you very much for your assistance. Should you have any concerns or questions regarding your patient's participation in therapeutic equine activities, please feel free to contact the center at the address/phone indicated above.

Sincerely,

Andrea Colella
Executive Director

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Participant's Medical History and Physician's Statement

Participant Name: _____ DOB:_____ Height: _____ Weight: _____
Address: _____
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: AtlantoDens Interval X-rays, date: _____ Result: + --

Neurologic Symptoms of AtlantoAxial Instability: _____

Please indicate current or past special needs in the following systems/areas, including surgeries:

	Y	N	Comments
Auditory			
Visual			
Tactile /Sensation			
Speech			
Cardiac			
Circulatory			
Integumentary/Skin			
Immunity			
Pulmonary			
Neurologic			
Muscular			
Balance			
Orthopedic			
Allergies			
Learning Disability			
Cognitive			
Emotional/Psychological			
Pain			
Other			

Given the above diagnosis and medical information, this person is not medically precluded from participating in equine assisted activities and/or therapies. I understand that From the Ground Up Therapeutic Horsemanship, Inc. will weigh the medical information given against the existing precautions and contraindications. Therefore, I refer this person to From the Ground Up Therapeutic Horsemanship, Inc. for ongoing evaluation to determine eligibility for participation.

Name/Title: _____ MD DO NP PA Other_____
Signature:_____ Date: _____
Address: _____
Phone: ( ) _____License/UPIN Number:_____

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Authorization for Emergency Medical Treatment Form

(for participant/rider)

Name: _____ DOB: _____ Phone: _____

Address: _____

Physician's Name: _____Preferred 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: _____

CONSENT PLAN

In the event emergency medical treatment is required due to illness or injury during the process of receiving services, or while being on the property of the center, I authorize_____ to:
(center's name)

1. Secure and retain medical treatment and transportation if needed.
2. Release participant records upon request to the authorized individual or agency involved in the medical emergency treatment.

This authorization includes X-rays, 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.

Date: _____ Consent Signature:_____
(Participant, Parent or Legal Guardian, signed in presence of center staff)

NON-CONSENT PLAN

I do not give my consent for emergency medical treatment/aid in the case of illness or injury during the process of receiving services or while being on the property of the center.

[ ] Parent or legal guardian will remain on site at all times during equine assisted activities

[ ] In the event emergency treatment/aid is required, I wish the following procedure to take place:

_____

_____

_____

Date: _____ Non-Consent Signature:_____
(Participant, Parent or Legal Guardian, signed in presence of center staff)

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Authorization for Emergency Medical Treatment Form

(for parent/guardian/volunteer)

Name: _____ DOB: _____ Phone: _____

Address: _____

Physician's Name: _____Preferred 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: _____

CONSENT PLAN

In the event emergency medical treatment is required due to illness or injury during the process of receiving services, or while being on the property of the center, I authorize_____ to:
(center's name)

1. Secure and retain medical treatment and transportation if needed.
2. Release participant records upon request to the authorized individual or agency involved in the medical emergency treatment.

This authorization includes X-rays, 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.

Date: _____ Consent Signature:_____
(Parent or Legal Guardian, signed in presence of center staff)

NON-CONSENT PLAN

I do not give my consent for emergency medical treatment/aid in the case of illness or injury during the process of receiving services or while being on the property of the center.

[ ] Parent or legal guardian will remain on site at all times during equine assisted activities

[ ] In the event emergency treatment/aid is required, I wish the following procedure to take place:

_____

_____

_____

Date: _____ Non-Consent Signature:_____
(*Parent or Legal Guardian, signed in presence of center staff)*

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Release of Liability

Witness this agreement this _____ day of _____, _____ by and between From the Ground Up Therapeutic Horsemanship, Inc. hereinafter referred as MANAGER, and RIDER, VOLUNTEER or GUEST (print name) _____, hereinafter referred to as RVG. For the consideration received, and in return for the use, today and on all future dates of the property, facilities and services of MANAGER, RVG, RVG's heirs, assigns, and representatives hereby agree as follow:

1. Inherent Risks and Assumption of Risk. The undersigned acknowledges there are inherent risks associated with equine activities such as described below and hereby expressly assumes all risks associated with participating in such activities. The inherent risks include, but are not limited to the propensity of equines to behave in ways such as, running, bucking, biting, kicking, shying, stumbling, rearing, falling or stepping on, that may result in an injury, harm or death to persons on or around them; the unpredictability of equine reaction to such things as sounds, sudden movement and unfamiliar objects, persons or other animals; certain hazards such as surface and subsurface conditions; collisions with other animals; the limited availability of emergency medical care; and the potential of a participant to act in a negligent manner that may contribute to injury to the participant or others, such as failing to maintain control over the animal or not acting within the participant's ability.

RVG acknowledges that horses, by their very nature are unpredictable and subject to animal whim. RVG assumes all risks in connection therewith, and expressly waives any claims for any injury or loss arising therefrom. RVG agrees to abide by and follow MANAGER's rules and regulations, which shall be posted and/ or available from time to time. RVG further acknowledges that the behavior of any animal is contingent to some extent upon the ability of the RVG. RVG assumes all risks therefore and warrants a full and fair disclosure of RVG's abilities has been made to the MANAGER.

2. RVG agrees to hold harmless, indemnify and defend MANAGER against, and hold harmless from, any and all claims, demands, causes of action, damages, judgments, orders, costs or expenses, including attorney's fees, whether actually incurred or not, which may in any way arise from or be in any way connected with RVG's use of or presence upon the property of MANAGER and the facilities located thereon.

3. In the event RVG is using RVG's own horse, or a horse(s) not owned by the MANAGER, RVG warrants said horse(s) shall be free from infection, contagious or transmittable diseases, MANAGER reserves the right to refuse access or use of any horse upon the premises that does not appear to MANAGER to be in good health, or is deemed dangerous or undesirable.

4. RVG agrees to waive the protection of any applicable statutes in this jurisdiction whose purpose, substance and/or effect is to provide that a general release shall not extend to claims, material or otherwise which the person giving that release does not know or suspect to exist at the time of executing said release.

_____ _____

MANAGER RIDER/VOLUNTEER/GUEST (RVG)

If RVG is under 18 years old, Parent or Guardian must sign:

Parent/Guardian
Signature:_____Date:_____