



Heritage Christian Stables
Operated by Heritage Christian Services
PO Box 200
Webster, NY 14580
585-872-2540
Fax: 585-872-4847
www.heritagechristianstables.org

Dear Participant,

Please review the enclosed information and policies. If you have any questions, please ask. Looking forward to a fantastic 2018 year!

Enrollment: Participants can enroll in any number of sessions during the year. Lesson time may include grooming and tacking. Once the paperwork is completed, new riders may be asked to come to Heritage Christian Stables for an evaluation to determine acceptance into the program. Riders are scheduled in compatible groups according to the lesson schedule. If Heritage Christian Stables is unable to accommodate a rider that has been evaluated and accepted into the program, the rider will be placed on a waiting list until an appropriate time slot becomes available. Riders will be accommodated according to compatibility, time availability, and horse usage.

Cost: Lessons cost \$40.00 and are approximately one hour in length with three or more riders, 45 minutes with two riders, one half hour with one rider. The session fee is payable *in advance* of the start of the session. If a rider needs financial assistance, ask Lorrie about availability. Your lesson fee covers 30% of the actual cost of rider participation. The remaining 70% is subsidized through fundraising, grants, sponsorships, individual donations etc. Heritage Christian Services encourages your participation in helping to offset the difference in cost through participation in fundraising events. Ask for more information.

** Please review updated weight information on the Information page near the end of the packet. **

Attendance Policy: If Heritage Christian Stables cancels lessons, a makeup or credit will be given for the lesson. If a rider cancels, no makeup will be provided. Policy allows one pre-arranged (prior to start of lessons) credit per session. Lateness (15 minutes or more) is considered a cancellation. Any requests for exceptions to this attendance policy must be made at the time of enrollment into the session. Riders *must be accompanied* by guardian/staff while at the stables.

Clothing: Riders must wear long pants. Shoes must be closed (toe and heel) and hard soled shoes with heels are preferred. Heritage Christian Stables has riding helmets available. Rider owned helmets are encouraged and must be ASTM-SEI approved for horseback riding and fit properly. Riders are to have no objects in their mouth as they can pose a choking hazard (ie: gum, hard candy, etc).

Forms: All forms must be completed prior to participation and are updated annually. Please keep any information pages for future reference.

Physical Address: Heritage Christian Stables is located at 1103 Salt Road, Webster, NY 14580.

Mailing Address: Heritage Christian Stables, PO Box 200, Webster, NY 14580



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Heritage Christian Stables 2018 Riding Sessions:

| Session | Session Dates | Session Length | Registration Deadline | Cost |
|----------------|---------------------------------|-----------------------|------------------------------|-------------|
| Snow Bunny | January 8 - February 17, 2018 | 6 weeks | December 18, 2017 | \$240.00 |
| Winter Classic | February 26 – April 21, 2018 | 8 weeks | January 29, 2018 | \$320.00 |
| Spring | April 30 – June 30, 2018 | 9 weeks | April 2, 2018 | \$360.00 |
| Summer | July 9 – September 1, 2018 | 8 weeks | June 11, 2018 | \$320.00 |
| Fall | September 10 – December 1, 2018 | 12 weeks | August 13, 2018 | \$480.00 |
| | | | | |
| December | TBA | | | |

Heritage Christian Stables 2018 Horse Show Dates: July 28, 2018

***** Please retain this page for your records*****



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Participant Registration

New Student _____ Continuing Student _____ Year _____

Snow Bunny ___ Winter Classic ___ Spring ___ Summer ___ Fall _____

*** Lessons are scheduled on a first come, first serve basis ***

Name _____ Date of Birth _____

Address _____ Best Phone _____

City _____ State _____ Zip Code _____

Current Weight _____ Changes in medical conditions _____

Email Address _____

To assist in lesson cancellations at HC Stables what is the best name and number to contact:

To help schedule lessons, please check **ALL** times you can ride. Please be accurate in regards to the time you can arrive. Checking all options does not mean that you would ride at all those times, but gives us more flexibility in scheduling. You will be contacted to confirm your time. Thank you.

| | Monday | Tuesday | Wednesday | Thursday | Friday | Saturday |
|-------------|--------|---------|-----------|----------|--------|----------|
| 10-11 am | | | | | | |
| 11:15-12:15 | | | | | | |
| 1:30-2:30 | | | | | | |
| 2:45-3:45 | | | | | | |
| 4:15-5:15 | | | | | | |
| 5:45-6:45 | | | | | | |
| 7:00-8:00 | | | | | | |

For Heritage Riders: Payment will be billed through Heritage Christian Services

For Community Riders: Payment is due prior to the start of the session

****Please note,** if the participant cancels from the above marked session *after scheduling* is completed and prior to the start of the session, there is \$50.00 cancellation fee. If the participant cancels *after that session has started*, the participant is responsible for full payment of the session. See Attendance Policy. **

Payment will be made by:

- Self Pay / Parent
 CAH Tab # _____
 Through HCS
 Self Directed
 Family Reimbursement
 Scholarship
 Other, please explain _____

~ Signature of person completing this form _____ Date _____

Please return to Heritage Christian Stables, 1103 Salt Road (PO Box 200), Webster, NY 14580

Questions? : Lorrie Renker, Director, 585.872.2540



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Participant's Application and Health History

GENERAL INFORMATION

Participant _____

Disability _____ Date of Onset _____

DOB _____ Age _____ Height _____ Weight _____ M F

Address _____

Street / PO Box City State Zip

Phone _____ Alternative Phone # _____

Employer / School _____ Phone # _____

Address _____

Street / PO Box City State Zip

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: Who to contact: _____ Phone# _____

HEALTH HISTORY

Please indicate current or past problems in the following areas:

| | Y | N | Comments |
|----------------------|---|---|----------|
| Vision | | | |
| Hearing | | | |
| Sensation | | | |
| Communication | | | |
| Heart | | | |
| Breathing | | | |
| Digestion | | | |
| Elimination | | | |
| Circulation | | | |
| Emotional | | | |
| Behavioral | | | |
| Pain | | | |
| Bone / Joint | | | |
| Muscular | | | |
| Thinking / Cognition | | | |
| Allergies | | | |

Tetanus Shot Yes _____ No _____ Date _____

What medication(s) is participant currently taking, including over-the-counter medication?

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

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

SOCIAL *(ie work/school including grade completed, leisure interests, companion animals, fears/ concerns, etc.)*

MANDATORY – Application incomplete unless filled in:

GOALS *(ie reasons for participation? What does the participant want to accomplish?)*

PREVIOUS EXPERIENCE *(does the participant have any previous experience with horseback riding? If yes, please describe).*

ADDITIONAL INFORMATION:

Signature _____ Date _____
(legal guardian)

Print Name and Relationship _____



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Participant's Team Collaboration Form

Participant's Name _____

Name of Service Coordinator _____ Phone _____ Email _____

Address _____ City _____ State _____ Zip _____

Name of Doctor _____ Phone _____ Email _____

Address _____ City _____ State _____ Zip _____

Name of Nurse _____ Phone _____ Email _____

Address _____ City _____ State _____ Zip _____

Participant receives the following collaborative services:

- | | |
|-------------------------------------|------------------------------|
| _____ Physical Therapist | _____ Recreational Therapist |
| _____ Occupational Therapist | _____ Music Therapist |
| _____ Speech and Language Therapist | _____ Art Therapist |
| _____ Psycho-therapist or Counselor | _____ Other _____ |

For all services checked above, please complete contact information: (use reverse if needed)

Service: _____ Name of provider _____ Phone _____ Email _____

Address _____ City _____ State _____ Zip _____

Service: _____ Name of provider _____ Phone _____ Email _____

Address _____ City _____ State _____ Zip _____

Service: _____ Name of provider _____ Phone _____ Email _____

Address _____ City _____ State _____ Zip _____

Service: _____ Name of provider _____ Phone _____ Email _____

Address _____ City _____ State _____ Zip _____

Service: _____ Name of provider _____ Phone _____ Email _____

Address _____ City _____ State _____ Zip _____

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. Heritage Christian Stables will keep this information confidential.

Signature of Legal Guardian: _____ Date _____



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Authorization for Emergency Medical Treatment Form

Participant Staff Volunteer

Name _____

Address _____

Street / PO Box City State Zip

Telephone _____ DOB _____

Physician's Name _____ 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 _____

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



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Liability Release and Photo Release Form

Liability Release

I/ my child would like to participate in the therapeutic horseback riding 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.

Consent Signature _____ Date _____
(*legal guardian*)

Print Name and Relationship _____

PHOTO RELEASE

- I **DO**
 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.

Signature _____ Date _____
(*legal guardian*)

Print Name and Relationship _____

****Medical History & Physician's Statement (To be completed by Physician)****

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Participant _____ DOB _____ Height _____ Weight _____

Street _____ 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

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

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

| | Y | N | Comments |
|-------------------------|---|---|----------|
| Auditory | | | |
| Visual | | | |
| Tactile Sensation | | | |
| Speech | | | |
| Cardiac | | | |
| Circulatory | | | |
| Integumentary / Skin | | | |
| Immunity | | | |
| Pulmonary | | | |
| Neurological | | | |
| Muscular | | | |
| Balance | | | |
| Orthopedic | | | |
| Allergies | | | |
| Learning Disability | | | |
| Cognitive | | | |
| Emotional/psychological | | | |
| Pain | | | |
| 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 _____

Address _____

Phone _____ License/UPIN number _____



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Information Concerning the Therapeutic Horsemanship Program

Therapeutic Horsemanship 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.

What are the Benefits: Physically, therapeutic riding can improve coordination and help normalize muscle tone. It can help improve posture and increase the 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 riding enhances the development of cognitive skills and allows the participant to improve socialization skills and learn team work.

How do you qualify to participate in the therapeutic horsemanship program?

- Riders over the age of four
- Meets the current horse weight requirements (200 pounds for balanced riders) Rider weight is determined at the start of each session and HC Stables reserves the right to weigh participants to determine accurate horse usage.
- Riders have appropriate behavior to maintain safety

The following conditions ARE contraindicated for therapeutic riding:

- 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:

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

Heritage Christian Stables may be unable to accommodate a potential rider due to resources available and program capabilities (ie: horses, equipment, instructors, volunteers and capabilities). Riders accepted into the program are re-evaluated on a regular basis and may become ineligible. The therapeutic riding program follows PATH's Precautions and Contraindications Guidelines.

If you have a question as to whether you qualify for the Therapeutic Horsemanship Program, contact: Heritage Christian Stables at 585-872-2540 or www.heritagechristianservices.org.



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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 is 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.**

- 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 spook or a misstep 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.

Contraindication:

- Children under the age of two
- Neurologic symptoms of atlantoaxial instability (see listing above)
- Positive neurologic clinical signs as noted by the physician
- Significant AAI measurement as determined by the physician
- Excessive head/neck instability with or without a helmet