2016 PROGRAM CLASS SELECTION FORM

***Please note that registrations are on a "first-come, first-served" basis.*

Rider Name_____ **Telephone Number** _____

Payment Type: _____**Private Pay** _____**Ridership** _____**Insurance** _____**Other**

Program Type: ____**Equine Therapy**
____**Adaptive Therapeutic Riding**
____**Veteran's Program**
____**Equine Facilitated Psychotherapy/Equine Facilitated Learning (contact Jennipher Vorhees)**

Please Indicate What Days You Can Attend:

____**Monday** ____**Tuesday** ____**Wednesday** ____**Thursday** ____**Friday**

BE AWARE that should you withdraw, you will be required to re-register.

In order for us to better serve you, please circle the goals below that are important to you.

Increase Strength – Endurance – Range Of Motion – Flexibility – Balance – Coordination – Posture – Sensory Processing Activities – Motor Planning – Self-Esteem – Confidence – Skill Development – Leisure Activity - Communication

****Remember, consistent attendance is necessary for progression in therapy, skill development***

FOR OFFICE USE ONLY: **DATE RECEIVED:** _____

PLEASE INDICATE REQUIRED VOLUNTEERS:

___*Leader* ___*Stand-By Leader* *1*__*or* *2*__*Sidewalkers*

Class Type _____ Class Day _____ Class Time _____

Instructor _____ Private _____ Semi-Private _____

Horse _____ Tack _____

2016 REGISTRATION FORM

Office Use Only: Date Rec'd_____

Class Type _____ Day_____

Client's Name _____ ☐ M ☐ F DOB_____

Home Address _____City_____State_____Zip_____County _____

Home Phone _____ Send all e-mail correspondence to this e-mail: _____

Ethnicity *(check all that apply)*: ☐ African American ☐ Asian ☐ Hispanic/Latino ☐ Caucasian ☐ Native American ☐ Multiethnic

Mother's Name_____Mother's Employer_____Job Title _____

Mother's Work Phone_____Mother's Cell Phone_____Mother's Email _____

Father's Name_____Father's Employer_____Job Title _____

Father's Work Phone_____Father's Cell Phone_____Father's Email _____

Client's Physician_____Physician Phone _____

Client's Therapist_____Therapist Phone _____

Has the client previously ridden at Chakota?
☐ YES ☐ NO

If you are a new Client, how did you hear about us: ☐ Physician ☐ Case Manager ☐ School ☐ Friend/Family ☐ Website ☐ Other _____

Current Residence (check one): ☐ Lives w/Family ☐ Foster Home ☐ Nursing Home ☐ Lives Independently Group Home ☐ Individualized Supported Living ☐ Specialized Facility

If Group Home, provide address and phone: _____

CLIENT PHYSICAL INFORMATION:

Height_____Weight_____ ☐ Verbal ☐ Non-Verbal

If you are a "Dept. of Mental Health" client, supply your DMH # here: _____

☐ Ambulatory ☐ Non-Ambulatory ☐ Wheelchair ☐ Walker ☐ Cane

Diagnosis _____

Seizure? Y N Allergies: _____

Medications _____

2016 Method of Payment

Rider Name:_____

Class Type:_____**Day:**_____**Time:**_____ **Start Date:**_____

Please read this form carefully. There are several important changes. ***THE EVALUATION FEE OF $25 IS DUE AT TIME OF EVALUATION FOR ALL NEW RIDERS.*** After you read through this form, please let us know of any questions about Chakota Therapeutic Riding Center's payment policies by calling Kay at 618-334-0885. We look forward to providing you/your child with a wonderful, therapeutic, and fun riding experience.

✱Each Rider/Rider's Legal Guardian Must Complete This Form✱

Chakota Therapeutic Riding Center accepts payment by Cash or Check

I will pay by Cash____ Check ___

Signature _____

Statements of Financial Responsibility

I accept full financial responsibility for all therapy services provided to the client named in this application, regardless of third-party coverage. I assume full responsibility in the event that the third party provider denies payment in full or in part.

Rider/Legal Guardian Signature_____ Date_____

I authorize Chakota Therapeutic Riding Center to provide any and all information to the above funding source in order for payment to be made on my/my child's behalf.

Rider/Legal Guardian Signature_____ Date_____

CHAKOTA Therapeutic Riding Center

Confidential Scholarship Application Form

☐ **I/We are private pay clients requesting financial assistance.**

☐ **Proof of income must accompany this form; accepted forms for proof of income are: prior or current month's paycheck stubs or current/prior year's income tax return (Please provide copies; originals are not necessary). Proof of income is required only once per year.**

Rider Name: _____

Parent(s) Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Day Phone: _____ Evening Phone: _____

Number of Individuals in Family: _____ I can pay $ _____ Towards monthly lesson fees

For which program offered through Chakota Therapeutic Riding Center are you requesting assistance? ***(Circle one.)***

Occupational/Physical/Speech Therapy Adaptive Therapeutic Riding EFL EFP Veterans Program

☐ **Please provide a 1 or 2 page letter of explanation for request. Applications without explanation will not be considered.**

INCOME

Source	**Amount**
Salary	_____/month
Spouse Salary	_____/month
Child Support	_____/month
ADC	_____/month
Medicaid	_____/month
Pension	_____/month
Social Security	_____/month
Disability	_____/month
Other	_____/month

EXPENSES *(general estimate)*

Source	**Amount**
Mortgage/Rent	_____/month
Utilities	_____/month
Food	_____/month
Child Care	_____/month
Medical Expenses	_____/month
Credit Cards	_____/month
Leisure	_____/month
Education/Tuition	_____/month
Other	_____/month

CHAKOTA Therapeutic Riding Center

Client Medical History & Physician's Statement

Participant:_____DOB:____HEIGHT_____WEIGHT____

Address:_____

Diagnosis:_____Date of onset:_____

Past/Prospective: _____

Medications:_____

Seizure Type:_____Controlled: Y N Date of Last Seizure_____

Shunt Present: Y N Date of last revision:_____

Special Precautions/Needs: _____

This individual demonstrates a need for assistance in "2" or more of these areas:_____Capacity for Living Independently
___Receptive & Expressive Language_____Learning_____Self Direction or Economic_____Self-Care_____Mobility

Mobility: Independent Ambulation Y N Assisted Ambulation Y N Wheelchair Y N

Braces/Assistive Devices:_____

For those with Down Syndrome: ***AtlantoDens Inverval X-rays, date:_____*** ***Result*** + -

Neurologic Exam that specifically denies any symptoms consistent with Atlanto Axial Instability was completed on, date:_____

Neurologic Symptoms of Atlanto Axial Instability: _____

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

To my knowledge, there is no reason why this person cannot participate in supervised equestrian activities. However, I understand that the therapeutic riding center will weigh the medical information above against the existing precautions and contraindications. I concur with a review of this person's abilities/limitations by a licensed/credentialed health professional (e.g., PT, OT, Speech, Psychologist, etc.) in the implementations of an effective equestrian program.

Name/Title_____MD DO NP PA Other _____

Signature:_____ Date: _____

Address: _____

Phone: _____ License/UPIN Number/NPI Number: _____

PHYSICIAN'S AUTHORIZATION

I hereby give medical authorization for (Client)_____to participate in the Chakota Therapeutic Riding Center program which includes an evaluation by a physician and/or occupational therapist to assess functional levels and recommend riding exercises. This Authorization does not constitute any medical assurance that the person named above will receive physical or psychological benefits from the program conducted by Chakota Therapeutic Riding Center, nor does it constitute an assessment of the risk of possible injury to said person in relation to the possible psychological or physical benefits from participating in the program.

The client's diagnosis is_____ **Diagnosis Code** _____

PHYSICIAN'S SIGNATURE: _____ **Date:** _____

If client has Downs Syndrome, has ADC (Atlantoaxial Dislocation Syndrome) been ruled out?_____If ADC is present, do you grant permission for the above named client to participate at Chakota Therapeutic Riding Center? **YES** **NO**

PHYSICIAN'S PRESCRIPTION

Please check all that apply.

☐ **Occupational Therapy** ☐ **Physical Therapy** ☐ **Speech & Language Pathology**

Client's Name _____ Phone _____

Prescription is for evaluation and treatment by a Physical, Occupational, and/or Speech Therapist.

Frequency:_____Precautions: _____

PHYSICIAN'S SIGNATURE: _____ **Date:** _____

Please print, type, or stamp: Physician's Name/Address/Phone _____

_____

RELEASE AND INDEMNITY AGREEMENT

(Please be aware this must be signed by Rider or Parent/Guardian.)

We, the parents* (guardian) / I (Client Name) acknowledge that I understand the medical authorization of (Physician)____does not constitute any assurance that I will receive physical or psychological benefits from the program conducted by Chakota Therapeutic Riding Center, or does it constitute an assessment of the risk of possible injury to me in relation to the possible physical or psychological benefits from participating in the program.

In consideration of the services and the medical authorization of (Physician)_____I hereby waive, release, and relinquish any and all claims against (him/her) for any and all liability arising from (his/her) authorization for me to participate in the program offered by Chakota Therapeutic Riding Center, and I hereby agree to hold harmless and to indemnify said physician against any and all claims arising from said authorization.

Under Illinois Law an equine professional is not liable for an injury to or the death of a participant in equine activities resulting from the inherent risks of equine activities pursuant to the revised statutes of Illinois

Date_____ **Signature of Applicant (over 18)** _____

Father_____**Mother** _____

*In the event that you have sole legal custody of or are the sole living parent of the above named child, only one signature is required.

CONSENT, RELEASE AND INDEMNIFICATION AGREEMENT

We, the parents* (guardian) of_____hereby consent to and assume the risk of our child participating in The therapeutic horsemanship program sponsored by Chakota Therapeutic Riding Center, under the supervision of Chakota Therapeutic Riding Center's trained riding instructors and which is conducted at Chakota Therapeutic Riding Center.

We/I acknowledge our understanding that there are no assurances that our child/I will receive physical or psychological benefits from participation in said program and our understanding that the ordinary risks associated with horseback riding.

For and in consideration of the agreement of Chakota Therapeutic Riding Center to provide riding instructions to aforesaid child/self, we do hereby forever release, acquit, discharge and hold harmless Chakota Therapeutic Riding Center, their officers, directors, agents, employees, representatives and any therapists, instructors, volunteers and other people associated with said program and the successors and assigns of each of them on account of any personal injuries, physical or mental condition, known or unknown, to the person of our aforesaid child/myself, and the treatment thereof, as a result of, or in any way growing out of the acts or omissions of said parties in connection with said services or in any way incidental thereto.

Under Illinois Law an equine professional is not liable for an injury to or the death of a participant in equine activities resulting from the inherent risks of equine activities pursuant to the revised statutes of Illinois.

Dated: _____ _____
Father (guardian)

_____
Mother (guardian)

_____
Self (If over 18 years of age)

*In the event that you have sole legal custody of or are the sole living parent of the above-named child, only one signature is required.

PHOTO RELEASE

For valuable consideration given and which is hereby acknowledged, the undersigned hereby_____**DO** grant or_____**DO NOT** grant to Chakota Therapeutic Riding Center permission to take or have taken, still and moving photographs, videos, and films including television pictures of our child/self_____and consents and authorizes Chakota Therapeutic Riding Center, its advertising agencies, news media and any other persons interested in Chakota Therapeutic Riding Center, and its work, to use and reproduce the photographs, videos, films, and pictures to circulate and publicize the same by all means including without limited the generality of the foregoing newspapers, television media, email newsletters, website, Chakota Therapeutic Riding Center social media channels (including, but not limited to, Facebook and YouTube), annual reports, brochures, pamphlets, fundraising materials, instructional materials, books and clinical material.

With regard to the foregoing material, no inducements or promises other than the intention of Chakota Therapeutic Riding Center to use or be used such photographs, videos, films, and pictures for the primary purpose of promoting and aiding Chakota Therapeutic Riding Center and its work.

Dated _____ **Signed** _____

CHAKOTA
Therapeutic Riding Center

Authorization for Emergency Medical Treatment Form

□Participant □Staff □Volunteer

Name:_____ DOB:_____ Phone:_____

Address:_____

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 emergency medical aid/treatment is required due to illness or injury during the process of receiving services, or while being on the property of the agency, I authorize_____

(Operating Center's Name)

To:

1. Secure and retain medical treatment and transportation if needed.
2. Release client 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.

Date:_____ Consent Signature:_____

Client, Parent, or Legal Guardian

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 agency. In the event emergency treatment/aid is required, I wish the following procedures to take place:

_____

_____

Date:_____Consent Signature:_____

Client, Parent, or Legal Guardian

RIDER'S BILL OF RIGHTS

CHOICE/PARTICIPATION - You have the right to choose and be included in any Chakota Therapeutic Riding Center program for which you are deemed eligible by our Program Director.
PROGRAM PLAN - You and /or your Legal Guardian have the right to participate in the development of your program plan which approximates your desired goals.
DIGNITY - You have the right to be treated humanely and with dignity at all times.
COMPLAINTS - If you are dissatisfied with anything at Chakota Therapeutic Riding Center, please discuss the matter with the Program Director. If the Program Director does not resolve the problem, the Executive Director will intervene with a mutually acceptable solution.

GRIEVANCE POLICY/PROCEDURE FOR RIDERS

GRIEVANCE POLICY: It is the policy of this agency to ensure maintenance of quality treatment, standards, and uniform compliance with established rules and regulations. All decisions involving involuntary or denial of admission will be subject to review on request of the client involved. The purpose of the Grievance Policy is to allow all clients and applicants for services the opportunity to appeal treatment decisions regarding involuntary termination, denial or admission, or other dissatisfaction with the agency's decisions affecting individual clients.

RIDER'S NAME_____

If I have any problems while I am receiving services through Chakota Therapeutic Riding Center, I understand that I and/or my Legal Guardian should first attempt to resolve the problem with your Program Director.

Michele A Jones-Vargas

_____ 618-616-5154
Michele Vargas, Program Director Phone Number

If I am not satisfied with the Program Director's solution, I should then discuss the problem mutually with the Program Director and the Executive Director.

Kay Langenhorst

_____ 618-334-0885
Kay Langenhorst, Executive Director Phone Number

I acknowledge receipt of the above. Rider/ Legal Guardian_____Date: _____

OPERATING CENTER MEMBER

Professional Association of Therapeutic Horsemanship, International

RESEARCH DATA RELEASE & CONSULTATION PERMISSION FORM

The undersigned hereby grant permission to use all test results and scores obtained from evaluation, both formal and informal, of child / self_____while said child/self was in attendance at Chakota Therapeutic Riding Center. Aforesaid material to be used for the purpose of research to be conducted only by the above named facility staff and/or consultants.

With regard to the foregoing statements, no use of the above name of child/self_____will be included in published material. No promises have been made to me/us to secure our/my signature(s) to this release other than the intention of the above named facility to use the test results and scores obtained from evaluations for the purpose of educational work and research.

I also give permission Chakota Therapeutic Riding Center's therapists to consult with my / my child's professional team (i.e., therapists, teachers, physicians) in order to prepare a comprehensive treatment plan.

Dated _____ Signed_____

CHAKOTA
Therapeutic Riding Center

General Liability Release

The undersigned is aware that all activities involving horses including but not limited to riding, driving, grooming, leading or events involving horses pose many inherent dangers, risks and hazards including but not limited to bodily injury and physical harm to rider, groomer, leader, handler, side walker, photographer, spectator and/or helper. I (the undersigned) freely assume all such risks, dangers, and hazards. I hereby agree as follows
(Initial each number to indicate that you have read, understand and agree):

_____1) To assume and accept all risks, dangers and hazards in connection with my use or my minor child's or ward's use of the facilities and activities at Chakota Therapeutic Riding Center, hereinafter ("Chakota") or any off site activities sponsored by Chakota.
_____2) To waive any and all claims that I may have against Chakota and the property owners as a result of my, my minor child or ward's use of the facility or participation in any off site activity sponsored by Chakota.
_____3) To release Chakota, its employees, board of directors, agents, volunteers, spectators, clients, guests, property owners and all people involved with Chakota from any and all liability, rights of action, or causes of action arising out of contract, tort or otherwise for any loss, damage, injury or expense that I, my minor child or ward, or next of kin of myself may suffer or incur as a result of use of the facilities and activities or participation in offsite activities sponsored by Chakota due to any cause whatsoever.
_____4) The undersigned agrees to hold harmless Chakota, and any employees, volunteers, board of directors, agents, spectators, clients and or property owners form any and all liability for personal injury, property damage or death suffered by myself, my minor child or ward or by a third party as a result of use and/or presence at the facility or activities or off site activities sponsored by Chakota.
_____5) That, in the event of my, my minor child or ward's injury or death, this release and indemnity agreement shall be effective and binding upon mine and my minor child or ward's heirs, next of kin, executors, administrators and assigns in relation to Chakota, it's property owners and any and all people involved.

Adult:
I acknowledge that I have read and understood this release. I am at least 18 years of age and am aware that by signing this document, I am releasing legal rights for myself, my heirs, next of kin, executors, administrators, and assigns or in relation to Chakota, its property owners and any and all people involved.

Date:_____ Name:_____ (print legibly)
Signature:_____
Witness:_____

Minor or ward:
I acknowledge that I have read and understood this release and indemnity. I am 18 years of age or older. I have the authority as the parent or legal guardian or legal representative of _____ (Please print legibly) to sign and release on behalf of the minor/ward so that the minor/ward may participate and use the facilities and activities offered by Chakota. I am waiving legal rights and liabilities of the minor/ward, his/her heirs, next of kin, executors, administrators, and assigns in relation to Chakota, its property owners and any and all people involved.

Date:_____ Name:_____ (print legibly)
Signature:_____
Witness:_____

CHAKOTA THERAPEUTIC RIDING CENTERNON-DISCRIMINATION POLICY

It is the policy of Chakota Therapeutic Riding Center to provide services to all persons without regard to race, color, national origin, religion, sex, age, or disability. No person shall be excluded from participation in or be denied the benefits of any service, or be subject to discrimination because of race, color, national origin, religion, sex age or disability.

STATEMENT OF PARTICIPANT ELIGIBILITY

Chakota Therapeutic Riding Center offers therapeutic riding to individuals with special needs. Eligibility for participation in Chakota's programs is based solely upon an individual's abilities to participate meaningfully and safely, provided there is an instructor/therapist, a horse, a volunteer, and a class available, which meets an individual's needs. Financial considerations are not taken into account in determining the eligibility for participation.

As a PATH Center Member, Chakota Therapeutic Riding Center fully ascribes to the Precautions and Contraindications as recommended by the Medical Committee of PATH. Therefore, all prospective riders are evaluated by our professional staff. This evaluation also requires that the prospective rider take part in a pre-ride assessment, conducted by the Chakota Therapeutic Riding Center Program Director.

Due to the nature of therapeutic riding, there are individuals for whom the Chakota Therapeutic Riding Center programs are deemed inappropriate during the evaluation process, and they are not accepted for enrollment. This determination is made on the basis of physical, behavioral, or other limitations.

Individuals accepted into the Chakota Therapeutic Riding Center program are required to take part in periodic reviews. During these reviews, or as the result of unusual occurrences during a program session, the TH professional staff may find that continuance in the program for a given individual is inappropriate. For this reason, Chakota Therapeutic Riding Center serves the right to discontinue the participation of a given individual in its programs when it is deemed that discontinuance is in the best interest of Chakota Therapeutic Riding Center and/or the individual concerned so the safety of any person or animal are not compromised.