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**Hazelwild Farm Therapeutic Riding Program
Registration and Release Form**

Rider's Name: _____ Date of Birth: ____/____/____ Age: _____ M or F
 Weight: _____ Height: _____ Disability: _____
 Parent/Guardian Name: _____ Cell Phone: (____) _____
 Street Address: _____ Home Phone: (____) _____
 City: _____ State: _____ Zip: _____
 Email Address: _____
 Business Name: _____ Business Phone: (____) _____
 Address: _____ City: _____ State: _____ Zip: _____
 Emergency Contact: _____ Phone: (____) _____ Cell: (____) _____
 School or Institution presently attending: _____
 Phone: (____) _____ Teacher's Name: _____

PHOTO RELEASE: _____ I hereby consent to and authorize í
 _____ I do not consent to and authorize í

The use and reproduction by Hazelwild's Heroes Therapeutic Riding of any and all photographs and other audio-visual materials taken of me/my child for promotional printed material, educational activities, exhibitions or any other use for the benefit of the program.

Signature: _____ Date: _____
 (If participant is a minor, parent/guardian signature is required)

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RIDER QUESTIONNAIRE

It is helpful for the staff to know of your interests and availability prior to scheduling and developing a program for you. Please complete the following questions.

Name: _____ Age: _____ Date: _____

What interests you in the Hazelwild's Heroes Therapeutic Riding Program?

What are your goals for the riding sessions? (i.e., riding skills, behavioral changes, physical improvements, paying attention, etc.) Please be specific.

What is your available schedule for riding? Please include days and times.

Please describe any previous horseback riding experience.

What other activities are of interest to you other than riding?

Do you need assistance with your payment? _____

Would you like a scholarship application? _____

How did you hear about our program? _____

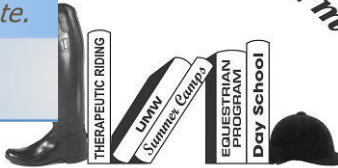
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DISABILITY DESCRIPTION

(Please answer where pertinent)

Name: _____ Age: _____ Date: _____

Disability: _____

Posture: _____

Balance: _____

Movement Coordination: _____

Behavior: _____

Attitude: _____

Perceptual Problems: _____

Communication Problems: _____

Mental Ability: _____

Precautions and/or Restrictions: _____

Suggestions: _____

Signature: _____ Title: _____ Date: _____

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CONSENT FOR RELEASE OF INFORMATION

I hereby authorize _____
(Person or Facility)

to release information from the records of _____
(Client's Name)

Date of Birth: _____

The information is to be released to Hazelwild's Heroes Therapeutic Riding Program for the above named student. The information to be released is marked below.

YES

- _____ Medical History
- _____ Physical Therapy evaluation, assessment and program plan
- _____ Occupational Therapy evaluation, assessment and program plan
- _____ Speech Therapy evaluation, assessment and program plan
- _____ Classroom Individual Education Plan (I.E.P.)
- _____ Other: _____

Signature: _____ Date: _____
(Client, Parent or Guardian)

Please send material to:

Hazelwild's Heroes Therapeutic Riding
5325 Harrison Road
Fredericksburg, Virginia 22407

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MEDICAL HISTORY / RELEASE

Name: _____ Date of Birth: _____

Address: _____

Disability/Diagnosis: _____ Date of Onset: _____

Height: _____ Weight: _____

Name of Parent/Guardian: _____

Tetanus Shot: () No () Yes Date: _____

Seizure Type: _____ Controlled: _____ Date of Last Seizure: _____

Medications: _____

Allergies: _____

**** FOR PERSONS WITH DOWNS SYNDROME ****

Cervical x-ray for Atlanto-Axial Instability:

() Positive () Negative X-ray Date: _____

Please indicate if patient has a problem in any of the following areas by checking yes or no. If yes, please comment, using the back of the paper if necessary.

Area	Yes	No	Comments
Auditory			
Visual			
Speech			
Cardiac			
Circulatory			
Pulmonary			
Neurological			
Muscular			
Orthopedic			

(Over)

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<u>Area</u>	<u>Yes</u>	<u>No</u>	<u>Comments</u>
Allergies			
Learning Disability			
Mental Impairment			
Psychological Impairment			
Surgery			
Other			

MOBILITY

Independent Ambulation: () Yes () No Crutches: () Yes () No
 Braces: () Yes () No Wheelchair: () Yes () No

Please indicate any special precautions:

In my opinion, this patient can participate in supervised equestrian activities. In conjunction with these activities, I concur in the referral of the patient to a physical or occupational therapist for evaluation of abilities/limitations in performing exercises and implementing an effective equestrian program.

Physician's Signature: _____

Date: _____

Physician's Name (please print): _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: (____) _____ Fax: (____) _____

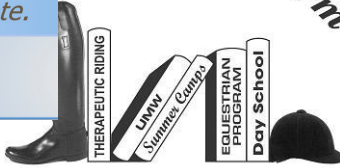
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Name of Patient: _____ Age: _____ Date: _____

SUMMARY OF PRESENTING PROBLEMS:

PSYCHOSOCIAL HISTORY:

MEDICATIONS/ALLERGIES:

DIAGNOSIS (DSM-IV-R):

- Axis I:
- Axis II:
- Axis III:
- Axis IV:
- Axis V: Current GAF 6

GOALS:

OTHER COMMENTS:

Please attach additional information.

Signature of Treatment Coordinator/Therapist: _____

Printed Name: _____ Date: _____

Address: _____

Phone: () - Fax: () -

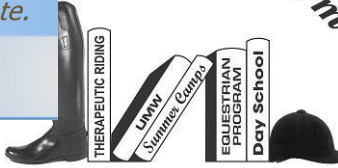
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PRIMARY PHYSICAL THERAPIST – PHYSICAL THERAPY EVALUATION

It is helpful for the staff to know of your interests and availability prior to scheduling and developing a program for you. Please complete the following questions.

Name: _____ Age: _____ Date: _____

General Information (brief history and muscle evaluation): _____

Joint Evaluation: _____

Behavior: _____

Functional Ability and Limitation Imposed by Reflexes: _____

Capable of Independent Sitting with Support? () Yes () No

Physical Therapy Program: _____

Goals: _____

Primary Physical Therapist's Signature: _____

Printed Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: () - Phone: () -

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AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT FOR RIDERS

In the event emergency medical aid/treatment is required due to illness or injury while being on the property of the Hazelwild Farm, I authorize HAZELWILD to:

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

In case of Emergency, contact _____ Phone _____

Or _____ Phone _____

Physician's Name _____ Town _____ Phone _____

Preferred Medical Facility _____

Health Insurance Carrier _____ Policy # _____

Medical conditions and/or medications we should know about: _____

Allergies _____ Other _____

Date of last Tetanus shot _____

CONSENT PLAN (To be invoked in the event that you Emergency contact cannot be reached) I give consent for emergency medical treatment/aid (including x-ray, surgery, hospitalization, medication and any treatment procedure deemed life saving by the physician) in the event of illness or injury while on the property of Hazelwild Farm.

Date _____ Consent Signature _____
(Parent or Guardian if volunteer is under 16 years of age)

NON-CONSENT PLAN I do not give consent for emergency treatment/aid in the event of illness or injury while on the property of Hazelwild Farm. In the event emergency treatment/aid is required, I wish the following procedures to take place: _____

Date _____ Non-consent Signature _____
(Parent or Guardian if volunteer is under 16 years of age)

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ATTENDANCE

1. Hazelwild expects regular attendance by all clients. Because of unforeseen circumstances that may arise, attempts will be made to schedule make-up lessons in the event of *notified* absences. **Refunds are not given for missed lessons.**
2. Clients who expect to be absent must notify Kristie via email, or telephone at least 24 hours prior to the scheduled lesson time. Two absences without notification, and more than two absences with or without notice may result in a client being placed on a waiting list.
3. The Hazelwild class schedule is subject to change. In the event of unforeseen circumstances, all reasonable attempts will be made to notify clients at least 2 hours prior to a schedule change. In the event Hazelwild must cancel a lesson, a credit will be applied to a lesson in another session.

PAYMENT

1. The fee is \$25 per lesson. The fees for each full session are due prior to the first day of class. A payment plan is available if needed, whereby 50% is payable prior to the first class, and 50% is payable mid-session (week 4 of an 8-week session, or week 3 of a 6-week session). The fees for Summer Camp and other programs are due prior to the start of each program, as specified in the enrollment packet.
2. A \$15 registration fee is required of all clients and prospective clients for each session. This is a non-refundable fee that helps defray the cost of processing the paperwork. This fee must accompany the completed forms at the time of the original application.

SCHOLARSHIP OPPORTUNITIES

The mission of Hazelwild's Heroes is to offer therapeutic riding services to as many clients as possible that may benefit from the program. Through fundraising, Hazelwild is able to offer scholarships up to the amount of funds available, in the form of adjusted fees to those who demonstrate a need. Clients may apply for a scholarship by writing a letter to the board of directors stating their circumstances and need. The board will notify those who qualify.

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DIRECTIONS TO HAZELWILD

From I-95: I-95 to Rt. 3 West. Go 6 traffic lights and turn Left onto Salem Church Road (Rt. 639). Go to second traffic light and turn left onto Harrison Road (Rt. 620). Go approximately 1 mile to Hazelwild Farm on Left ó before the I-95 overpass.

From Warrenton: Take US-17 South to I-95. Go South on I-95 one exit to Rt. 3 West. Follow above directions.

From Culpeper: Take Rt. 3 East and turn Right onto Harrison Road (Rt. 620). Continue for approximately 4 miles to Hazelwild located on the Left ó before the I-95 overpass.

From Richmond: Take I-95 North to Massaponax exit. Go North on US-1 and turn Left onto Harrison Road (Rt. 620). Cross over I-95. Turn Right into the first drive.

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