Cheryl Baker, CEO

Board of Directors:
Robert Makos, *Chairperson*
Colleen Krcelich, *Vice Chairperson*
Denise deMena, *Treasurer*
Adele E. Fagan, *Secretary*
Alice Balsone
Wenda Boyer
Ronald F. Brubaker
Bernard Bujnowski
Diane Cavanagh, Ed.D.
Mark Culp, P.E.,LEED A
Timothy J. Duckworth, Esq.
Mark Hartney
Kimberly Hirschman
Casey Noble
Lynne Paul
Elizabeth Scofield

Polly Beste, *Chairperson Emeritus*

524 Fehr Rd.
Nazareth, PA 18064

Tel. 610-365-2266
Fax 610-365-2263

www.equi-librium.org

Partner Agency

2017 Season

Dear Prospective Participant:

Thank you for your interest in the Therapeutic Horsemanship programs of Equi-librium. We were pleased to hear from you and look forward to your participation.

Enclosed are the Registration forms for you to fill out. You may access our Participant Handbook by going our website, www.equi-librium.org. If, after reviewing the information, you wish to apply for acceptance into any of Equi-librium's programs, please complete all the information requested and return the forms to our office.

Upon receipt of your forms, we will contact you to discuss program options, fees, payment arrangements, and the days and times available to you. An evaluation may be required prior to participation to determine which program is best for you and your participant. Evaluations are conducted by one of our certified instructors or therapists. We also encourage you to come and visit our center at any time prior to your evaluation or start of session.

Applicants are admitted into program on a first come, first serve basis depending upon the openings we have and the availability of instructors, volunteers, horses and the day and time you can come. Every effort will be made to provide an opportunity within as short a time as possible. You will be kept informed of the progress of your application by phone or email.

The registration fee of $20.00 is due at time of registration. Fees for service are due prior to the start of the session. We have provided a payment instruction sheet for you that outlines procedures and methods of payment.

If you should have any questions or concerns, please do not hesitate to call me at 610-365-2266. We look forward to serving you.

Best Regards,

Debra Hutchison
Program Director

An approved Educational Improvement Organization (EIO) under the PA Department of Community and Economic Development EITC program.

The official registration and financial information of Equi-librium may be obtained from the Pennsylvania Department of State by calling toll free within Pennsylvania, 1- 800-732-0999. Registration does not imply endorsement.

524 Fehr Rd.
Nazareth PA 18064
Office (610)-365-2266
Fax (610)-365-2263
Email:debbie@equi-librium.org
Website: www.equi-librium.org

PARTICIPANT APPLICATION/REGISTRATION - 2017

First Name: ________________________ MI: __________ Last Name: ______________________

Address: ____

City/Town: ________________________ State: ________________ Zip: ____________________

County: _________________________ Township: _______________________________________

Date of Birth: _________________ School District: __________________________________

Diagnosis: ____

Parents: Father _____________________________ Mother ______________________________

Legal Guardian (Parent(s) or other) ____

Guardian's or Parent's Address: (If different than participant) __________________________ ______________

Employment: Father ________________________ Mother ___________________________________

Phones: Home: _________________________ Email: _______________________________________

Mother Work: ____________________ Father Work: _________________________________

Mother Cell: _____________________ Father Cell: __________________________________

Fax: ____________________________

For Statistical Purposes Only
Gender *(Male/Female)*: _________ Ethnicity *(Caucasian, African American, Hispanic, etc.)*: ______________________

Primary Language *(English, Spanish, French, etc.)*: ____

How did you hear of Equi-librium? ____

Have you attended another therapeutic riding/driving program? _____ Yes _____ No

If so, where and what were you doing? ____

PLEASE COMPLETE REVERSE SIDE OF THIS FORM

Participant Authorization for Emergency Medical Treatment

Please read and sign one of the Consent Plans Below

CONSENT PLAN

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 or program site, **I authorize Equi-librium to**:

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 .

Name of Participant ________________________________ Phone:____________________

Address:____

In the event I, or my parents, guardian, or caregiver cannot be reached please contact following person(s):

Contact____ Phone: ________________

Contact____ Phone: ________________

Physician's Name: ____

Physician Address: ________________________________ Phone: _______________________

Preferred Medical Facility:____

Health Insurance Co: ________________________________ Policy #:_____________________

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 contact person listed above is unable to be reached.

Date: _____________ **Print Name**: ______________________________________

Consent Signature: ____

Participant or Parent/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 or program site. In the event emergency treatment/aid is required, I wish the following procedures to take place:

____

____

____

Date: __________ **Print Name**: ____

Non-Consent Signature: ____

Participant or Parent/Legal Guardian

EQUI-LIBRIUM, INC.
PARTICIPANT SESSION, DAY/TIME PREFERENCE – 2017

Name of Participant: ____

Date: ___________________________

Please indicate which program you are applying for, and check off your preferred day and/or time as indicated. Please note the descriptions on Method of Payment form.

Session Selection

Please refer to the Program Calendar on the back of this form for the 10 Week Session Dates. Please indicate the session(s) for which you are registering. *Please make sure you check all of the sessions in which you wish to participate.*

____ **Winter** ____**Spring** ___ **Summer** ___ **Fall** ____ **Extended Fall**

Program Selection

______ **Developmental Riding and Movement Experience - $500**
(One on one with an Instructor with volunteer assistance – Times scheduled by arrangement)
Day Preference: _____Monday ____Tuesday ____ Wednesday, _____ Thursday

_______Friday _____Saturday _______Morning _____Afternoon

______ **Therapeutic Cart/Carriage Driving - (**One on one**) $450**
(Times will be scheduled by arrangement.)
Day Preference: _____Monday _____Tuesday ____ Wednesday, ____ Thursday

______Friday _____Saturday ________ Morning ________ Afternoon

______ **Trail Blazers/ Group Sessions –** (One instructor, 3-4 in a group) **$350**

Please number your Day and Time Preferences with a 1, 2 or 3.

____ Monday ____Tuesday ____ Wednesday ___Thursday _____ Friday ______Saturday

Monday - Friday Times: ____4:00pm _____5:00pm ____6:00pm _____7:00pm

Saturday Times: ____9:00 ____10:00am _____11:00am ____1:00pm ____2:00pm

______ **Semi-Private Instruction - $400** (By arrangement)

______ **Private Instruction - $450** (For independent riders/by arrangement)

______ **Hippotherapy – $800 PT or OT Therapist, One on one**
(to be arranged with Program Director and dependent on availability of therapist)

Time Preference: _____9AM _____10AM _____11AM _____Noon,

_____1PM ____2PM ____3PM _____4PM

Equi-librium, Inc. 524 Fehr Rd. Nazareth PA 18064
Office (610)-365-2266, Fax (610)-365-2263
E-mail:debbie@equi-librium.org

PARTICIPANT MEDICAL HISTORY AND PHYSICIAN'S STATEMENT

(To be completed ONLY by PHYSICIAN)

Name: ______________________________ Date of Birth: ________________

Address: ____________________ City ______________ State ________ Zip ________

Name of Parent/Guardian: ____

Diagnosis (and ICD9#): ____________________________ Date of Onset: ____________

For Persons with Down Syndrome: AtlantoDens Interval X-Rays, Date __________ Results: Pos Neg

Neurologic symptoms of AtlantoAxial Instability: ______________________________

Past/Prospective Surgeries: ____

Tetanus Shot: Yes No Date: __________ Height: __________ Weight: __________

Shunt Present: Yes No Date of last revision: ______________________________

Seizure Type: ________________ Controlled: Yes No Date of last seizure: __________

Medications: ____

Mobility Independent Ambulation: ÎYes ÎNo / Crutches: ÎYes ÎNo / Braces: ÎYes ÎNo / Wheelchair: ÎYes ÎNo

Special Precautions/Needs: ____

Please indicate if participant has a problem and/or surgeries in any of the following areas by checking yes or no. If yes, please comment.

Areas	Yes	No	Comments
Auditory			
Visual			
Speech			
Cardiac			
Circulatory			
Pulmonary			
Neurological			
Muscular			
Orthopedic			
Balance			
Allergies			
Learning Disability			
Mental Impairment			
Cognitive			
Emotional/Psychological			
Integumentary/Skin			
Other			

Please See Other Side

To my knowledge there is no reason why this person cannot participate in supervised equine assisted activities. However, I understand that Equi-librium, Inc. 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, Social Worker, Teacher, etc.) in the implementing of an effective equestrian program.

Physician Name (please print):______________________________

Address: ______________________ City: ______________ State: ______Zip: __________

Phone: __________________ FAX: ______________ Date: ______________________

Physician Signature: ______________________________

Information for Physicians

The following conditions, if present, may represent precautions or contraindications to equine-assisted activities, including horseback riding. Therefore, when completing this form, please note whether these conditions are present, and to what degree.

Orthopedic
Spinal Fusion
Spinal Instabilities/Abnormalities
Atlantioaxial Instabilities
Scoliosis, Kyphosis, Lordosis
Hip Subluxation and Dislocation
Osteoporosis
Pathologic Fractures
Coxas Arthrosis
Heterotopic Ossification
Osteogenesis Imperfecta
Cranial Deficits
Spinal Orthoses
Internal Spinal Stabilization Devices

Neurologic
Hydrocephalus/shunt
Spinal Bifida
Tethered Cord
Chiari II Malformation
Hydromyelia
Paralysis due to Spinal Cord Injury
Seizure Disorders

Medical/Surgical
Allergies
Cancer
Poor Endurance
Recent Surgery
Diabetes
Peripheral Vascular Disease
Varicose Veins
Hemophilia
Hypertension
Serious Heart Condition
Stroke (Cerebrovascular Accident)
Medically Unstable (eating disorders, addictions, seizures, etc.)

Other Concerns
Behavioral Problems (acting out, antisocial, agitation, etc.)
Age under 2 years
Age 2-4 years
Acute exacerbation of chronic disorder
Indwelling catheter
Gross Obesity

Mental Health
Contraindications:

- dangerous to self or others (homicidal, suicidal, aggressive)
- delirious, demented, disassociative, hallucinatory, severely confused
- substance abusing or detoxing

Precautions:

- persistent delusion around the elements (esp. horse)
- exhibiting abusive behaviors
- history of untreated animal abuse/fire setting

Symptoms of Atlantoaxial Instabilities

- Loss of Head Control - a) head tilt, b) stiff neck, c) torticollis
- Loss of Hand Control - a) fisting, b) change of dominant hand, c) progressive weakness, d) increasing tremor
- Change in Gait - a) toe walking or scissoring, b) progressive clumsiness, c) falling, d) posturing
- Loss of Bladder or Bowel Function

EQUI-LIBRIUM, INC.
Therapeutic Horsemanship
524 Fehr Rd. Nazareth PA 18064
(ph)610-365-2266; (fax)610-365-2263

MEDIA RELEASE

PARTICIPANT

Our Equi-librium participants, families and volunteers are our best advocates! We occasionally have the opportunity to feature one of our Equi-librium children or adult participants or volunteers in the media, including printed material, television, newspaper, radio or the Internet, to promote Equi-librium programs and services.

Please indicate your Media Consent or Non-Consent Below

CONSENT: ☐ **Please check box**

I hereby grant permission for Equi-librium, Inc. to use photographs, videos, quotes, or information regarding:

______________________________________ for Equi-librium promotional purposes.
(Name of Participant- Print)

NON-CONSENT: ☐ **Please check box**

I do not grant permission for Equi-librium, Inc. to use photographs, videos, quotes or information regarding:

______________________________________ for Equi-librium promotional purposes.
(Name of Participant – Print)

Signature of Participant (18 or over only) ______________________________

Signature of Parent(s)/Guardian ______________________________
(Mother's Signature)

____
(Father's Signature)

____
(Legal Guardian)

Date ________________

Please Note: The person or persons having legal custody of the participant must sign this form. In cases of joint or shared custody both persons must sign this form.

PARTICIPANT
ACKNOWLEDGEMENT OF RISK
ACCEPTANCE OF RESPONSIBILITY, RELEASE OF LIABILITY AND IDEMIFICATION

I, the undersigned, hereby acknowledge that I have voluntarily applied to have myself or my son/my daughter/my ward engage in equine-assisted activities that include horseback riding with Equi-librium, Inc.

I understand the activity of horseback riding and other equine-assisted activities involves numerous inherent risks of injury both known and unknown that are an integral part of such an activity. I knowingly and freely assume full responsibility for myself or for my son/ my daughter/ my ward for all such risks, whatever the cause even if arising from the negligence of Releasees (as herein after defined) or others.

I and/or my family further understand that an animal, irrespective of its training and usual past behavior and characteristics, may act or react unexpectedly or unpredictably at times, and I also assume such risks for myself or my son/ my daughter/ my ward.

As consideration for being permitted by Equi-librium, Inc. to engage in equine-assisted activities including horseback riding, I, for myself and on behalf of my heirs, successors, assigns, personal representatives, executors and next of kin. do hereby waive any claim and release, indemnify Equi-librium, Inc. and all of their owners, officers, members, affiliated organizations, agents and/or employees other participants, successors, assigns, sponsoring agencies, sponsors, advertisers, and if applicable, owners and lessors of the premises used for the equine-assisted activities (Releasees) with respect to any and all injury, disability, death, or loss or damage to person or property associated with my presence or participation in equine-assisted activities including horseback riding whether arising from the negligence of the Releasees or otherwise, to the fullest extent permitted by law.

This contract shall be legally binding upon me, my heirs, my estate, assigns, legal guardians, and my personal representatives.

On February 21, 2006, Pennsylvania's Equine Activity Act went into effect. This act applies to an individual, group, club or business entity that sponsors, organizes, conducts or provides the facilities for an equine activity where a sign indicating that "You assume the risk of equine activities pursuant to Pennsylvania law." This sign is conspicuously posted at the Equi-librium Therapeutic Horsemanship Center.

I have carefully read this agreement and fully understand the contents. I am aware that I am releasing certain legal rights that I otherwise may have, and I enter into the contract in behalf of myself and/or my family of my own free will.

Name of Participant: ______________________________

Signature of Participant: ______________________________
(18 or over only)

Signature of Parent(s)/Legal Guardian: ______________________________
(Mother's Signature)

____
(Father's Signature)

____
(Legal Guardian)

Date: ____________________

Please Note: The person or persons having legal custody of the participant must sign this form. In cases of join or shared custody both persons must sign this form.

EQUI-LIBRIUM, INC.
Equine Assisted Services
Input Form for Individual Program Plans – 2017

Participant Name: ____

Parent/Guardian Signature: ___________________ Date: _______________

Equi-librium, Inc. creates **Individual Program Plans (IPP's)** for each participant. Every participant will follow the usual lesson progression in either remedial vaulting or functional riding skills. While the program plan will include expected skill progressions, we would also like to write participant-oriented outcomes that reflect the strengths or weaknesses that you, as the participant or family/caregiver, feel the program can effectively and positively impact.

Check on the list below, **3** general categories of development that you feel the Equi-librium program could **specifically benefit you or your rider** during this year's program. Please place a number 1 through 3 in order of importance. Do **not** check areas that you or your rider have no difficulty with and would be expected to show progress in regardless of program participation. These areas can be updated at any time. If there is a specific area listed, i.e. balance, imitation, or colors for example, that you especially want targeted, please circle that specific area as well.

_____ Physical Mobility – ability to physically move within the barn environment
_____ Postural and midline control, balance
_____ Body awareness, body parts, imitation
_____ Sensory processing of touch, motion, position/pressure, visual & auditory input
_____ Directionality, laterality, spatial relations
_____ Motor planning of body &/or an activity, eye-hand coordination
_____ Fine motor skills – reaching, grasping, manipulation
_____ Eye contact, attention span
_____ Communication, following directions, answering questions
_____ Sense of safety, impulse control
_____ Independence, responsibility, self-control, self-care
_____ Functional academics- counting, shapes, colors, letters, matching, sequencing, reading

What **specific activities/skills/behaviors** are you working on at home or in school that you feel could be incorporated into your or your participant's program? Please list below:

____
____
____
____

Would you be willing to share your IEP or IPP from school or another agency with us to better serve you?
_____Yes _____No

Do you have any objections to the program incorporating any of the following **communication aides** into you or your rider's program if the instructor feels it would be beneficial and are appropriate to you or your participant's needs? (Sign language, communication symbols/board, electronic communication devices)
Yes ___ No ____

2017 PROGRAM CALENDAR

Dates are subject to change depending on weather conditions, horse changes, or other circumstances. The following holidays are observed: New Year's Day, Memorial Day, July 4th, Labor Day, Thanksgiving and Christmas. **Exact session dates may end on different dates depending on the day and when holidays fall. There also may be changes due to special Equi-librium activities or cancellations. Weekly schedules start on Monday.**

All Therapeutic Horsemanship Programs for 2017:

Winter: **Start: Week of January 9th**
End: Week of March 13th
No makeups: You will be billed in advance for 5 lessons; pay as you go for balance

Spring: **Start: Week of March 20th**
End: Week of May 22nd
Make-ups: Week of May 29th (Monday participants will be billed for 9 weeks due to Memorial Day)

Summer: **Start: Week of June 5 th**
End: Week of August 7th
Make-ups: Week of August 14 th (Tuesday participants billed for 9 weeks due to July 4th)

Summer Break: **Week of August 21st**

Summer Camps: **June 19-23 ages 4-7; July 10-14 ages 8-12;**
July 24-28 ages 13-18+; August 14-18 ages 4-7

Fall: **Start: Week of August 28th**
End: Week of October 30th
Make-ups: Week of November 6th (Monday and Saturday participants billed for 9 weeks due to Labor Day and Horse Show)

Horse Show: September 30th

Extended Fall: Start: Week of November 13th
End: Week of December 18th
(No Make-up sessions for Extended Fall)

Volunteer Training Schedule: BASIC: March 11th; March 18th; April 8th; May 13th; June 10th; July 8th; August 12th; September 9th; October 14th; All are held from 12:30pm-3:30

Additional Trainings will be held throughout the year as needed; see Volunteer board and volunteer news page on website for topics and dates/times.

Equi-librium, Inc.

PAYMENT INSTRUCTIONS – 2017

Due to the need for timely payment of fees to Equi-librium, we are asking all registrants to review the following information and fill out the attached form. Include payments or vouchers along with your registration as applicable. Once your registration has been received, you will be billed for your first session. *If you have signed up for multiple or later sessions during the year, you will be billed one month prior to those sessions.* Payment will be due upon receipt of the invoice.

All Registrants:

- Enclose the **annual registration fee of $20.00** along with your Registration Information Update. (FDFSS does not always pay this fee. If they do, you may include the fee on your voucher or waiver information. You must make sure they will pay this fee.)
- **Outstanding fee balances from previous sessions must be paid in full prior to starting any sessions in 2017.**
- **All fees must be paid, vouchers received or payment arrangements made prior to the start of any 2017 session.**
- Except for Winter and Extended Fall sessions, **all programs are 10 week tuition based programs. ONE absence will be allowed (unless otherwise noted due to holiday) and a make-up week will be offered at the end of each session. Any absences occurring through Equi-librium cancellations will be credited to your account and may be used for a riding lesson within the 2017 program year. No refunds will be given.**
- If for any reason late payments occur, a 1.5% interest charge will be added to any overdue balances of 60 days.

Registrants paying through FDFSS Funding:

- Enclose an **FDSS Voucher** if you are paying through MH/MR FDSS funding. ***(If you do not provide a voucher your registration or start of program will be delayed until one is received.)*** Upon receipt of the voucher, Equi-librium will bill the provider of those paying through FDFSS or Waiver. You will also receive a bill for your records. You are responsible for knowing how much is in your FDFSS account, and are responsible for payment of any funds not covered by FDFSS.

As stated in the opening Letter, you must make sure that you have adequate money in your FDSS funds account. You must verify this with your caseworker prior to the start of program.

PLEASE FILL OUT METHOD OF PAYMENT FORM ON NEXT PAGE →→→→

EQUI-LIBRIUM, INC.
METHOD OF PAYMENT FORM
To be returned with Registration Information

Name of Participant: ______________________________

Signature of Person Filling out this Form: ______________________________

As a participant in the program(s) of Equi-librium, it is your understanding and commitment to pay the applicable fees for service. Indicated below is the method of payment by which these fees are to be paid. Please place your INITIALS next to the check (√) mark the method you are using, and complete accordingly.

Registration Payment **Amount**

√_____ **$20.00 Registration Fee Enclosed, All Participants** __________
(This fee is to be paid with registration.)

_____ **Payment by Check Enclosed** **Check #** __________

_____ **Payment by Credit Card**
(Please call the office to provide your card information, (610-365-2266)

Fees for Service PAYMENT will be paid by: Please INITIAL the appropriate line at the check mark for the program you will be attending. Please do not pay these fees now; you will be billed.

√ **Personal/Private Pay:**

Trailblazers Group	$350	__________
Developmental Riding	$500	__________
Sensory Integration /Movement Experience	$500	__________
Trailblazers Semi-Private	$400	__________
Trailblazers Private/Independent	$450	__________
Therapeutic Cart/ Carriage Driving	$450	__________
Hippotherapy	$800	__________

_____ **Payment by Check Enclosed** **Check #** __________

_____ **Payment by Credit Card** **See Attached Form**

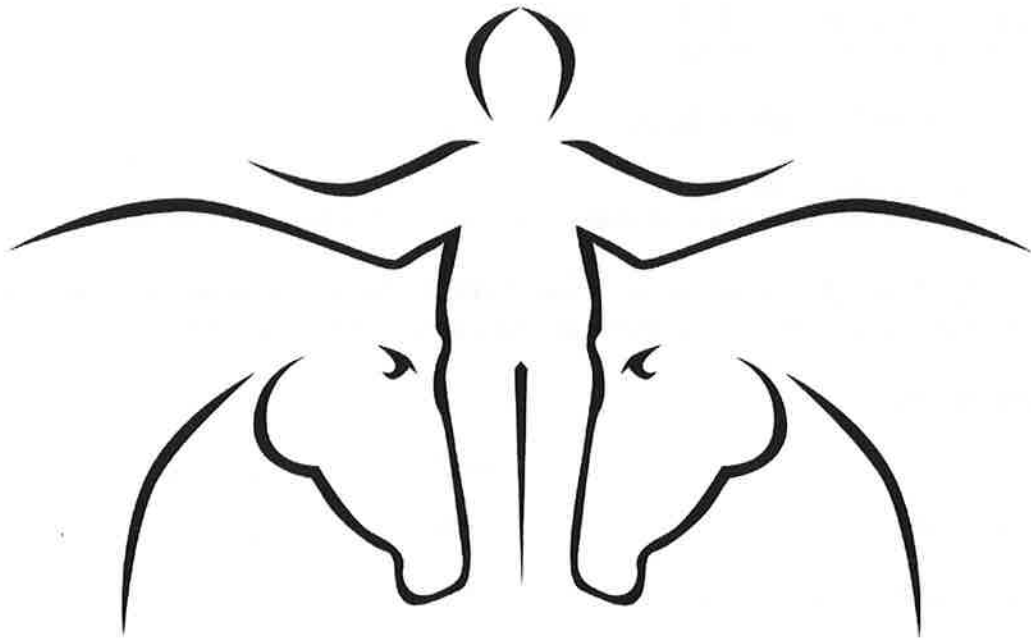
√_____ **FDFSS Voucher Enclosed (You must enclose a voucher with Registration and you must let us know the name of your caseworker**

Payment Provider _____ **Easter Seals Eastern PA**

Other ______________________________

Name of MH/MR Caseworker ______________________________

______ **Other Payer** ______________________________



EQUI~LIBRIUM

Therapeutic Horsemanship