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 - 2018

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. 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

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.
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.

EQUI-LIBRIUM, INC.
Therapeutic Horsemanship
Input Form for Individual Program Plans – 2018

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, writing
_____ Functional riding skills

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 ____

2018 Program Calendar

Therapeutic Horsemanship Programs for 2018:

Winter: Start- Tuesday, January 2, 2018
Last Day- Saturday, March 10th.
Winter session will be billed in advance for 5 lessons with payment in full according to lessons attended beyond 5. Should weather not permit at least 5 lessons, credits will be applied to the spring bill. No make-ups are available for winter.

Spring: (10 week tuition based session with 11th week set aside for one make-up)
Starts Monday, March 12. 2018
Last day for spring session: May 19th
Make-up week runs from May 21-26th

Spring Break: Monday, May 28-June 2, 2018
No make-ups or lessons scheduled

Summer: (10 week tuition based session with 11th week for one make-up)
Starts Monday, June 4, 2018
Last Day- Saturday, August 11th
Make-up week runs from August 13th-18th

Summer Camps:
Monday, June 18th – Friday, June 22nd **(ages 4-7)**
Monday, July 9th- Friday, July 13th **(ages 8-12)**
Monday, July 23rd – Friday, July 27 **(ages 13 +)**
Monday, August 13- Friday August 17th **(ages 4-7)**

Summer Break: Monday, August 20th – Saturday, August 25th
No lessons or make-ups scheduled.

Fall Session: (10 week tuition based session with 11th week set aside for 1 make-up.)
Starts- Monday, August 27th
Last Day- Saturday, November 3
Make-up week runs from November 5th-10

Extended Fall Session:
Starts Monday, November 12
Last Day- December 22, 2018
No make-up day for the extended fall session

Volunteer Trainings
Saturday, February 24; March 3; April 14; May 12; June2: July 14; August 11; September 8 and October 6.
Training time is from 12:30-3:30
Other dates will be added to calendar for Leader training.

Equi-librium, Inc.

PAYMENT INSTRUCTIONS – 2018

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 the Spring 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 2018.**
- **All fees must be paid, vouchers received or payment arrangements made prior to the start of any 2018 session.**
- Except for Hippotherapy, Extended Fall and Winter session, **all programs are 10 week tuition based programs. ONE absence will be allowed and a make-up week will be scheduled at the end of the ten week session. Any absences occurring through Equi-librium cancellations will be credited to your account.**
- If for any reason late payments occur, a 1.5% interest charge will be added to any overdue balances of 30 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.)*** As stated in the opening letter, you are responsible for knowing if adequate funding is available to you. If you are unsure contact your support coordinator prior to the start of program. Upon receipt of the voucher, Equi-librium will generate a bill through you and will submit that bill to the FDFSS or Waiver program. If we receive notice that there are not adequate funds available, you are responsible for the balance not covered by FDFSS or Waiver program.

Please note that all of Equi-librium's Programs are therapeutic by design and therefore may be different than any other riding/driving experience. Participants should come into the sessions having no preconceived notions about riding/driving, techniques, grooming, and basic horsemanship. These sessions are designed to achieve specific results and as such you/your participant may be asked to ride, groom, hold reins and work with our horses and instructors very differently than you may have experienced before. We ask that you be receptive to new ideas, new ways and trust that there are time-honored and industry-wide principles for what we will ask a participant to do. We may require volunteers to be involved in the session in addition to an instructor. This is not an indication of inability, but simply due to what is being accomplished within each lesson. We have each participant's safety and goals in mind.

*****Please Select Program, Day/Time and Method of Payment on Next Page*****

EQUI-LIBRIUM, INC.

PARTICIPANT SESSION, DAY/TIME PREFERENCE – 2018

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 (Cost based on 10 week tuition based session)

_______ **Hippotherapy $80 per session (Billed Monthly)**
_______ **Developmental Riding - $500**
_______ **Sensory Processing and Movement Experience- $500**
_______ **Trail Blazers Private Instruction- $450**
_______ **Trail Blazers Semi-Private Instruction- $400**
_______ **Trail Blazers Group- $350**
_______ **Therapeutic Carriage Driving- $450**
_______ **Silver Saddles: ____ Private $450; ____ Semi-private $400; ____ Group $350**

- **Please number your Day and Time preferences with a 1, 2 and 3.**

____ Monday ____ Tuesday ____ Wednesday _____ Thursday ____ Friday ____ Saturday

Morning: ___ 9:00 ___10:00 ___11:00
Afternoon: ___ 12:00 ___ 1:00 ___ 2:00 ___ 3:00 ___ 4:00
Evening: (Monday- Friday only) ___ 5:00 ___6:00 ___ 7:00

- **METHOD OF PAYMENT**

______ Payment by check _____ Payment by Credit Card

(Please call the office 610-365-2266 with card information or we now have the option to pay online at www.equi-librium.org, mouse over healing through horses and click on program payments)

_____ $20 Registration Fee Enclosed
_____ FDFSS Voucher Enclosed

Other Payment Provider_________________________

Signature of person completing form ________________________________