HIGH HOPES
Therapeutic Riding, Inc.

Dear High Hopes Horse Sense Participants, Parents and Friends:

Horse Sense is designed around an experiential and educational curriculum which utilizes the horse as our fellow teacher as we delve into topics such as community, responsibility, team work and volunteerism, as well as offering some opportunities for a mounted experience a top our equine partners. Horse Sense is offered to children entering into grades 5-8 in order to participate in our mounted activities participants must meet our weight limit of 180lbs so that we may ensure the longevity of our beloved herd of horses.

Our staff strives to create an integrated experience for all participants. We ask that both parents and participants help us to quantify the success of this pilot by contributing feedback on the program through survey and written response. High Hopes strives to offer the highest quality or programming; we greatly appreciate your current support and continued participation in this exciting new endeavor.

What will my child experience, learn and discover in Horse Sense?

COMMUNITY BUILDING: Explore and demonstrate communication, responsibility, respect and camaraderie with peers and our horses.

HORSEMANSHIP: Discover how to build a lasting partnership with horses and what it means to be a responsible horse owner. Experience horseback riding and its benefits.

LEADERSHIP AND TEAM: Explore and demonstrate the meaning of team and leadership with our horses and peers.

Participants are required to complete all necessary paperwork including documentation from a physician stating that riding is an appropriate activity. **High Hopes reserves the right to decide if we are unable to serve an applicant due to resource and or/safety concerns outlined in the NARHA guidelines precautions and contraindications for participation.**

> ***Has your child participated in any of our programs within the past two years? You may not need to complete ALL of our forms – contact our staff for more information!***
> Please note: Application forms are still required on an annual basis (applications cannot be taken over the telephone).

Deadline for applications has been extended; please inquire directly to High Hopes regarding availability. Paperwork must be received with full payment in order to reserve your child's placement. Participants' applications will be reviewed and selected while upholding the spirit of our integrated approach. Confirmation letters will be sent **after** July 11th. A wait list is maintained in the event of cancellations.

Cancellation Policy:
A 50% reimbursement of payment will be issued IF a cancellation is made *four or more weeks* **before** the beginning of the session. After that time, there is no refund.

> **** High Hopes Summer Camp is licensed through the State of Connecticut and requires Parents/guardians requesting medication administration to their child during camp hours to provide appropriate written authorization(s) and the medication to be administered. (THIS INCLUDES EPI-PENS, INHALERS, ORAL AND TOPICAL MEDS)**
> **At your request we will provide a copy of our medication administration policy or refer to our website.**

Please feel free to call with questions at 860-434-1974, Ext. 18, or email lbrown@highhopestr.org.

Sincerely,

Laura Brown
Special Programs Manager/Camp Director

36 Town Woods Rd., Old Lyme, CT 06371
860.434.1974 • Fax 860.434.3723 • www.highhopestr.org

HIGH HOPES 2011 Horse Sense
APPLICATION AND RELEASE FORM
(REGISTRATION DEADLINE HAS BEEN EXTENDED)

Name: ________________________________ Date of Birth: ____/____/____ Age: __________
Weight: ________ Height: _________ Disability/Diagnosis/Pertinent Information: ______________________
Allergies: ____
Medications that will be needed during camp hours: ______________________________
Parent/Guardian Name: ____________________________________
Street: ______________________ City: ______________ State: _________ Zip: ____________
Home Phone: ______________________ Business Phone: ______________________
E-mail: ____
Emergency Contact Person #1 ______________________ Phone: (   ) ________-___________
Emergency Contact Person #2 ______________________ Phone: (   ) ________-___________

Where did you hear about our Camp? (Please circle) CT Camping Association Friend Internet Flyer Other ___________

First Session Choice
(Please Circle)

1	**Aug 1- Aug 4**	**(Mon – Thurs, 9:00am – 1:00pm)**	**Fee: $150**
2	**Aug 8- Aug 11**	**(Mon – Thurs, 9:00am – 1:00pm)**	**Fee: $150**
3	**Aug 15- Aug 18**	**(Mon – Thurs, 9:00am – 1:00pm)**	**Fee: $150**

If your first choice is filled, and you would like to be considered for alternate sessions, please indicate order of preference:

____

PHOTO RELEASE: _____ I hereby consent to and authorize
_____ I do not consent to nor do I authorize

High Hopes Therapeutic Riding, Inc. 1) to use my child's photograph or image in its print, online and video publications; 2) release High Hopes Therapeutic Riding, Inc., its employees and any outside third parties from all liabilities or claims that I might assert in connection with the above-described activities and 3) waive any right to inspect, approve or receive compensation for any materials or communications, including photographs, videotapes, DVDs, website images or written materials, incorporating photos/images of me(my child).

Date: ______________ Signature: ____________________________________

LIABILITY RELEASE (Required): ___________________________ (Name) would like to participate in the High Hopes Summer Camp Program. I acknowledge the risks and potential for risks of horseback riding and related equine activities, including grievous bodily harm. However, I feel that the possible benefits to myself/my child/my ward are greater than the risk assumed. I hereby, intending to be legally bound for myself, my heirs and assigns, executors, and administrators, waive and release forever all claims for damages against High Hopes Therapeutic Riding, Inc., its Board of Directors, Instructors, Therapists, Aides, Volunteers, and/or Employees for any and all injuries and/or losses I/my child/my ward may sustain while participating in the Program from whatever cause including but not limited to the negligence of these released parties.

The undersigned acknowledges that he/she has read this Registration and Release Form in its entirety; that he/she understands the terms of this release and has signed this release voluntarily and with full knowledge of the effects thereof.

Date: ____________________ Signature: ____________________________________

Please return with payment to: High Hopes TR, Inc., 36 Town Woods Road, Old Lyme, CT 06371
REGISTRATION DEADLINE HAS BEEN EXTENDED

36 Town Woods Rd., Old Lyme, CT 06371
860.434.1974 • Fax 860.434.3723 • www.highhopestr.org

(Horse Sense)
AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

______Participant ______Staff ______Volunteer

Name:________________________________DOB:________________Phone:________________________________

Physician's Name: __________________________ Preferred Medical Facility: ____________________________

Health Insurance Co: ____________________________________ Policy #:____________________________________

Current Allergies, Medications, and Health Concerns: ____

____

____

In the event of an emergency:

Emergency Contact 1:____Relation:___________________________

Home Ph: ________________________ Work Ph: ______________________ Cell Ph: ________________________

Emergency Contact 2:____Relation:___________________________

Home Ph: ________________________ Work Ph: ______________________ Cell Ph: ________________________

In the event that 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 HIGH HOPES THERAPEUTIC RIDING, INC. 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 (to be invoked in the event that your 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 the agency.*

Date: __________________ Consent Signature:____

Client, Parent, or Legal Guardian

*** If you choose non-consent for emergency medical treatment/aid in the event of illness or injury while on the property of the agency, please request a Non-Consent Form, which requires notarization.**

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(Horse Sense)

Date: ______________________________

Dear Physician:

Your patient, ____ (participant's name) is interested in participating in supervised equestrian activities.

In order to safely provide this service, our center requests that you complete/update the attached Medical History and Physician's Statement Form. Please note that the following conditions may suggest precautions and contraindications to therapeutic horseback riding. Therefore, when completing this form, please note whether these conditions are present, and to what degree.

Orthopedic
Atlantoaxial Instability – include neurological symptoms
Coxa Arthrosis
Cranial Deficits
Heterotopic Ossification/Myositis Ossificans
Joint subluxation/dislocation
Osteoporosis
Pathologic Fractures
Spinal Fusion/Fixation
Spinal Instability/Abnormalities

Neurologic
Hydrocephalus/Shunt
Seizure
Spina Bifida/Chiari II malformation/Tethered Cord/
Hydromyelia

Other
Age – usually under 4 years
Indwelling Catheters
Medications, i.e., photosensitivity
Poor Endurance
Skin Breakdown

Medical/Psychological
Allergies
Animal Abuse
Physical/Sexual/Emotional Abuse
Blood Pressure Control
Dangerous to self or others
Exacerbations of medical conditions
Fire Settings
Heart Conditions
Hemophilia
Medical Instability
Migraines
PVD
Respiratory Compromise
Recent Surgeries
Substance Abuse
Thought Control Disorders
Weight Control Disorder

Thank you very much for your assistance. If you have any questions or concerns regarding this patient's participation in therapeutic equine activities, please feel free to contact the center at the address/phone indicated below.

Sincerely,

Laura Brown
Special Programs Manager

(Over)

PARTICIPANT'S MEDICAL HISTORY & PHYSICIAN'S STATEMENT (Horse Sense)
Physical Exams Are Valid For 3 Years From Date of Last Examination

Participant: ______________________________ DOB: ________ Height: _____ Weight: _____
Address: ____
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, Diets/Needs: ______________________________________
_____May participate in all activities _____May participate except for: ______________
Mobility: Independent Ambulation? Y N Assisted Ambulation? Y N Wheelchair? Y N
Braces/Assistive Devices: ______________________________________
***For those with Down Syndrome:* AtlantoDens Interval X-rays, date: _________ Result: + -**
Neurologic Symptoms of AtlantoAxial Instability: ______________________________

This participant is up-to-date on all the following routine childhood immunization:

Immunization	Y	N	Date:	Immunization	Y	N	Date:
Measles				Hepatitis B			
Rubella				Mumps			
Tetanus				Chicken Pox			
Pertussis				Other:			
Polio							
Diphtheria							
Pneumococcal Conjugate							

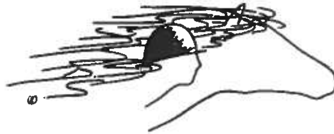
Please indicate current or past difficulties in the following systems/areas, including surgeries:

	Y	N	Comments:
Auditory			
Visual			
Tactile Sensation			
Speech			
Cardiac			
Circulatory			
Integumentary/Skin			
Immunity			
Pulmonary			
Neurologic			
Muscular			
Balance			
Orthopedic			
Allergies			
Learning Disability			
Cognitive			
Emotional/Psychological			
Pain			
Other			

***IMPORTANT NOTE TO DOCTOR/MEDICAL FACILITY:* If you prefer to provide this information on your own medical form, we will accept that only when this release section is completed, signed & dated & your form is stapled to our form.**

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 referral of the patient to a licensed/credentialed health professional (e.g., PT, OT, Speech, Psychologist, etc.) in the implementation of an effective equestrian program.

Name/Title: ______________________________ MD DO Other: ______________
Signature: ______________________________ Date: ______________
Address: ____
Phone: ____________________ License/UPIN Number: ______________



HIGH HOPES
Therapeutic Riding, Inc.

POTASSIUM IODIDE (KI) FACT SHEET AND PERMISSION FORM (Horse Sense)

The State of Connecticut is making Potassium Iodide tablets (KI) available to child care facilities and youth camps within the 10-mile emergency planning zone around Millstone Power Station in Waterford, CT. KI is a form of iodine. It helps to protect the thyroid gland when there is a chance that you might be exposed to a harmful amount of radioactive iodine. In the rare event of a nuclear emergency, your child care provider will be directed when to administer KI through the Emergency Alert System (EAS). Children in child care and youth camps are of the age most likely to suffer the effects of radioactive iodine. Your childcare program or youth camp must obtain your written consent in order to administer KI pills to your child/children. Please remember that the administration of KI to your child under these emergency conditions is voluntary.

Contraindications:

- Your child should not take Potassium Iodide if he/she is allergic to iodine.
- Your child should not take Potassium Iodide if he/she has chronic hives.
- Although a single tablet of KI should be tolerated by most people, some (particularly adults), with a number of rare diseases and conditions should discuss this issue with their physicians. These conditions include:
  - Hypocomplementemic vasculitis, possibly as a component of lupus or chronic hives,
  - Autoimmune thyroid disease, such as Graves disease.
- Potential side Effects: Please consult with your pediatrician if your child experiences any of these side effects:
  - Minor upset stomach
  - Rash

POTASSIUM IODIDE (KI) CHILD MEDICATION AUTHORIZATION FORM

______Participant ________Volunteer

Name:____ Date of Birth:__________________

Street____

City:_________________________________ State:_______ Zip:______________________

Please indicate your authorization or refusal by marking the appropriate line below:

_______YES, I want my above named child to be administered KI by High Hopes when: The Governor declares a nuclear emergency, AND individuals in specified area, that includes this child care facility/youth camp, are advised by the Emergency Alert System (AES) to take the Potassium Iodide (KI) tablets AND I understand that the ingestion of Potassium Iodide (KI) under these circumstances is voluntary.

_______ NO , I do NOT want my above named child to be given Potassium Iodide (KI) by High Hopes in the event of a nuclear emergency. I have been advised in writing by the facility about the contraindications and the potential side effects of taking Potassium Iodide. I understand that it is my responsibility to notify High Hopes in writing if I desire to change my authorization as indicated above.

____

(Parent/Guardian Signature) (Date)