



Dear High Hopes Riders, Parents and Friends:

Plans for **Summer Camp 2010** are underway! We are offering an enhanced curriculum, challenging skill levels and offering additional educational opportunities. Summer Camp is open to High Hopes riders, as well as children in the surrounding communities. Our staff strives to create an integrated experience for all participants. We will explore:

COMPLETE HORSE CARE: Participants are assigned a horse to call their own for the full, four day session. They will become familiar with grooming, tacking, and bathing, as well as shoeing requirements and veterinary needs.

HORSEMANSHIP: Up to 1-1/2 hours of riding is offered daily.

STABLE MANAGEMENT: Participants become familiar with the horse's needs. Activities include cleaning a stall, pasture maintenance, and feeding.

SPECIAL PROJECTS: These may include crafts, trail riding, games on horseback, and nature hikes. Guest presenters will speak on a variety of topics such as vaulting, carriage driving, equine massage and other equine care.

FOUR sessions are offered during the 2010 Summer Camp. A description of each session is attached. We are encouraging younger participants to join this year as an introduction to riding – see sessions 1 & 2. All instructors are members of the High Hopes staff.

Please note: Applications cannot be taken over the telephone AND we must receive applications with payment in full by the registration deadline in order to accept placement in a session.

If you would like to participate in our 2010 Summer Camp, **please complete the enclosed application forms and return them with payment in full** to High Hopes by **March 1, 2010**. Applications will be reviewed and participants selected based upon maintaining the spirit of our integrated approach.

Confirmation of registration and tuition invoices for payments not yet received will be mailed **after** March 15. A wait-list is maintained in the event of cancellations.

If you must cancel a Summer Camp Program registration, 50% of any money paid will be issued IF the cancellation is made *four or more weeks* **before** the beginning of the session. After that time, there is no refund. In the event that you give a choice of sessions, your application will be listed for your first choice. Should your first choice session already be filled by the time your application is received, I will call you to help determine the next best suited session based on the subsequent choices listed on your registration form.

Please feel free to call me at 860-434-1974, Ext. 18, or email lbrown@highhopestr.org, if you have any questions. Hope to see you here!

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 2010 SUMMER CAMP*****

PLEASE NOTE - THIS YEAR SESSION DATES ARE NOT CONSECUTIVE!!

SUMMER CAMP SESSION 1

June 28 - July 1

Fee: \$375.00

Designed as an INTRODUCTORY session for youngsters ages 3-6 years that have little to no horse experience. This is also a great way for younger siblings of riders to be able to get their seat in the saddle and have fun with horses!

Space limited to maximum of 16 participants.

Monday - Thursday, from 9:00 AM to 1:00 PM.

SUMMER CAMP SESSION 2

July 12 - July 15

Fee: \$375.00

This session is designed for our younger horse enthusiasts, ages 3-6 years, as an introduction to horses and riding. Learn the basics of equine communication, grooming, tack identification and basic riding skills.

Space limited to maximum of 16 participants.

Monday - Thursday, from 9:00 AM to 1:00 PM.

SUMMER CAMP SESSION 3

July 19 - July 22

Fee: \$375.00

Session for 7 - 12 year olds who have minimal riding experience and who want to learn more about horses and horsemanship! Riders will develop their basic riding skills at the walk and trot and learn about taking care of horses!

Space limited to maximum of 16 participants.

Monday - Thursday, from 9:00 AM to 1:00 PM.

SUMMER CAMP SESSION 4

July 26 - July 29

Fee: \$375.00

For 10 - 14 year olds who are able to control their horse independently at the walk and trot and have developed a strong, balanced seat and are beginning to canter. Let our certified instructors carry them forward in a safe, structured lesson plan that will allow them to grow wings!

Space limited to maximum of 16 participants.

Monday - Thursday, from 9:00 AM to 1:00 PM.

****** All SUMMER CAMP PROGRAM sessions offer the opportunity to experience Vaulting and Carriage Driving, too!******

FOR MORE INFORMATION, CONTACT LAURA AT HIGH HOPES:

(860) 434-1974, Ext. 18 or lbrown@highhopestr.org

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**HIGH HOPES 2010 SUMMER CAMP PROGRAM
APPLICATION AND RELEASE FORM
(REGISTRATION DEADLINE IS MARCH 1st, 2010)**

Name: _____ Date of Birth: ____/____/____ Age: _____
Weight: _____ Height: _____ Disability/Diagnosis/Pertinent Information: _____
Parent/Guardian Name: _____
Street: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Business Phone: _____
Emergency Contact Person #1 _____ Phone: () _____ - _____
Emergency Contact Person #2 _____ Phone: () _____ - _____

Has the rider participated in our Therapeutic Riding Program OR Summer Camp Program before?

_____ YES _____ NO When? _____

Please describe the riding skill: Never Ridden _____ Beginner _____ Intermediate _____
Advanced (able to walk/trot/beginning canter) _____

First Session Choice

(Please Circle)

- | | | | |
|---|-------------------|-------------------------------|------------|
| 1 | June 28 – July 1 | (Mon - Thurs, 9:00am- 1:00pm) | Fee: \$375 |
| 2 | July 12 - July 15 | (Mon - Thurs, 9:00am-1:00pm) | Fee: \$375 |
| 3 | July 19 – July 22 | (Mon - Thurs, 9:00am-1:00pm) | Fee: \$375 |
| 4 | July 26 – July 29 | (Mon - Thurs, 9:00am-1:00 pm) | Fee: \$375 |

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

Rider's T-Shirt Size: Child's Small _____ Child's Medium _____
Adult's Small _____ Medium _____ Large _____ X-Large _____

PHOTO RELEASE: _____ I hereby consent to and authorize

_____ I do not consent to nor do I authorize

the use and reproduction by High Hopes Therapeutic Riding, Inc. of any and all photographs and other audiovisual materials taken of me for promotional printed material, educational activities, exhibitions or for other use for the benefit of the program.

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 IS MARCH 1, 2010

36 Town Woods Rd., Old Lyme, CT 06371
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HIGH HOPES
Therapeutic Riding, Inc.

(Summer Camp Program)
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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HIGH HOPES
Therapeutic Riding, Inc.

CONSENT FOR RELEASE OF INFORMATION (Summer Camp Program)

I hereby authorize _____
Person(s) or Place(s) releasing information

to release information from the records of _____,
Participant's name

DOB: _____.

The information is to be released to High Hopes Therapeutic Riding, Inc. for the purpose of developing an equine activity program for the above-named participant.

The information to be released is marked below.

____ Medical History

____ Physical Therapy evaluation, assessment and program plan

____ Occupational Therapy evaluation, assessment and program plan

____ Speech Therapy evaluation, assessment and program plan

____ Psychosocial evaluation, assessment, program plan, discharge summary

____ Classroom Individual Education Plan (I.E.P.)

____ Cognitive-Behavioral Management Plan

____ Other: _____

Date: _____ Signature: _____
Client, Parent or Legal Guardian

Please send the indicated material to High Hopes at the address below. Thank You!

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HIGH HOPES
Therapeutic Riding, Inc.

(Summer Camp Program)

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 (Summer Camp Program)

Participant: _____ DOB: _____ Height: _____ Weight: _____

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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:

	Y	N	Date:
Measles			
Rubella			
Tetanus			
Pertussis			
Polio			
Diphtheria			
Other:			

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: _____

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