Equine-Assisted Therapy, Inc.

Therapeutic Horseback Riding

3369 Hwy 109, Wildwood, MO 63038

Come ride with us at www.eatherapy.org

Hello,
Thank you for your interest in participating at Equine-Assisted Therapy, Inc. As a previous volunteer, a Certified Instructor, and the parent of a child who took part in our program, I have seen firsthand the positive benefits of equine therapy for my own child and our family.

Our mission is to provide horsemanship experiences to those with mental, physical, and psychological challenges and disabilities in order to enhance the healing, quality, and productivity of their lives.

It is my hope that you find EAT comfortable and inviting as you see improvements while participating in our equine programs. Much goes into the placement of a participant in our programs and we will do the very best at finding the right class. If at any time you have questions or concerns, please reach out to me.
Here are a few things you will need to know before your first session with us:

**Our riders must wear an equestrian helmet. It must be an SEI Certified Equestrian Riding Helmet that meets or exceeds ASTM1163-01 standards. You are welcome to borrow one ours to get sizing and to make sure equine therapy is going to be a good fit for you and your family before purchasing one. If you do have your own helmet they expire after 5 years-it is your responsibility to make sure the helmet is up to date and up to current standards.*
**Our participants must wear closed toed shoes at all times while in the arena.*
**All our instructors are certified on one of the 4 main certifying entities in our industry, most have more than one certification. We also have a PT, LPC, SLP, and OT on our core team of professionals.*

Welcome to our EAT family and I hope to meet you soon.
Walk on,
Lulu Bogolin
Executive Director

Our programs:
Equine Adaptive Activities-are group classes where participants are riding the horse with a trained leader and side walker(s). They are working on riding skills while also gaining core strength, balance, fine and gross motor skills, sensory processing, socialization, and building self-esteem. Weight limit is 225 lbs.
Equine Assisted Learning-Is a non-riding program. This is a self-awareness and relationship skills building program that focuses on personal growth, relationships, and boundaries while being with a horse. Can be private or in a group, group is a min of 4 persons. Helmets are required if under the age of 14.
Silver Saddles-is a riding program for those who are 55+. This program works on balance, coordination, flexibility, and memory retention. This program intentionally tracks at a slower pace than a traditional riding school as we focus on both personal development and technical riding skills. Weight limit is 225 lbs.
Boots in the Barn-is a program offered to Veterans and First Responders who are looking for opportunities around the barn to help release the stresses that come with these titles. This can be a riding or non-riding program as well as therapy or volunteer opportunity. Weight limit for riding is 225 lbs.

Equine-Assisted Therapy, Inc.

To apply:

1. Fill out the application form completely. *All forms must be signed by BOTH parents/legal guardians.* We do need page 6 signed by the participants physician.

2. Return the completed application to our Wildwood location (3369 Hwy 109 Wildwood MO 63038) or email to info@eatherapy.org or fax to 636-587-6100

3. Please fill out the application to the best of your ability. The more information you can provide us about the participant the better. Additional information is key if available. For example, the rider does not like hats or may hit occasionally. Do not be afraid to share with us the worst and the best of the participant. This allows us to find the best class and team fit, helps in lesson plans, healing and reaching our goals.

4. Will we contact you as soon as your application is received. We do have a waiting list so we will ask about best times for you and your family and let you know as soon as we have an opening that will fit your schedule, that matches the goals and abilities of the participant, and close in age range with the participant. We also look at the best horse, instructor, and volunteers for each participant. Much goes into fitting a rider to a class. While you may be the last person on the waiting list, you may be the best fit for the next open spot.

5. We will let you know as soon as we have an opening that we feel is a good fit, but you are welcome to check in with us from time to time. You do not have to reapply each session, but we do require a new application each year.

6. We have a 24-hour cancellation policy. If you cancel within 24 hours of your session, you will be charged for your class. _____

7. We will bill at the beginning of each session. If payment is not received by the beginning of the following session, we will charge your card on file and your lesson time will be given to another participant. _____

8. We ask that you not bring any tablets or speaking devices to class without speaking to your instructor and our team first.

9. Hitting or hurting the horse or team members continuously will not be tolerated. While we understand sensory situations and will work our best through them, our animals and our team members are our livelihood. We are not here to discipline; we are here for healing and helping each participant to reach their goals.

10. Equine-Assisted Therapy does not discriminate based on disabilities, race, sex, age, religion, or ability to pay.

Name:_____ **Signature**:_____ **Date**:_____

(First parent/legal guardian OR Participant if 18 or older)

Name:_____ **Signature**:_____ **Date**:_____

(Second parent/legal guardian)

Equine-Assisted Therapy, Inc.

Date: _____

Preferred Location: Wildwood - Town & Country - Either

Program:

☐ Equine-Adaptive Activities/Riding ☐ Equine-Assisted Learning ☐ Other Group
☐ Silver Saddles ☐ Boots in the Barn

Contact and Personal Information

Last Name:_____ **First Name**:_____ **Preferred Name**:_____

Sex: Male - Female - Gender Neutral **Date Of Birth**:_____ **Age**:_____ **Height**:_____ **Weight**:_____

Parent/Legal Guardian(s) Name_____

Email:_____ **Home Phone**:_____ **Cell Phone**:_____

Address:_____ **City, State**:_____ **Zip Code**:_____

Would you like to receive our newsletter? Yes - No

How did you hear about us? Flyer - TV - Service Group - School - Special Event - Internet - Referral - Other

If referral or other please list name and/or explain_____

Therapeutic and Riding History

Participant Diagnosis:_____

When was participant diagnosed? At Birth - Result of an accident (accident date_____) - Other
Please explain other_____

Does the participant use any of the following aids? Wheelchair - Cane - Braces - Walker - Crutches - Other (Please explain)_____

Has participant ever ridden a horse or been involved in therapeutic riding before? No - Yes
If yes please explain and for how long_____

Other types of therapy participant is in or has done in the past:_____

Other extra-curricular activities participant is in:_____

Were you referred by a medical professional or government agency? Yes - No
Reason they referred you? _____

Information on this form may be used in the preparation of grant applications for participant funding: however, names will be kept strictly confidential

***WARNING:* UNDER MISSOURI LAW, AN EQUINE PROFESSIONAL OR ANY EMPLOYEE/VOLUNTEER THEREOF, IS NOT LIABLE FOR AN INJURY TO OR THE DEATH OF A PARTICIPANT IN EQUINE ACTIVITIES RESULTING FROM THE INHERENT RISKS OF EQUINE ACTIVITIES PURSUANT TO THE REVISED STATUTES OF MISSOURI. R.S.Mo.§537.325**

Equine-Assisted Therapy, Inc.

More About You

Occupation:_____ **Employer:**_____

Parent/Legal Guardian or Spouse Occupation:_____ **Employer:**_____

Program Goals:

What are your short-term goals: (i.e., riding skills, behavioral changes, physical changes, improvements, -please be specific)

1.

2.

3.

What are your long-term goals? Please be specific.

1.

2.

3.

What outcomes would you like to see when these goals are achieved?

1.

2.

3.

What additional information can you share with us about the participant? (Use of aids, how to regulate, health concerns, likes or dislikes)

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Equine-Assisted Therapy, Inc.

Participant Authorization for Emergency Medical Treatment

This form is valid for a period of 1 year from the date signed. Please attach the completed medical history to this form.

In the event emergency medical aid/treatment is required due to illness or injury during the process of receiving services, or while on the property of the agency, I authorize Equine-Assisted Therapy, Inc. to:

1. secure and retain medical treatment and transportation if needed; and
2. release participant records upon request to authorized medical personnel.

Participant's Name:_____ **Phone:** _____
In the event of an emergency contact:_____ **Phone:**_____
Second emergency contact:_____ **Phone:**_____
Physicians Name:_____ **Phone:**_____
Preferred Medical Facility:_____
Health Insurance Company:_____ **Policy #:**_____

Consent

Consent is given for emergency medical aid/treatment in the case of illness or injury during the process of receiving services or while of the property of Equine-Assisted Therapy, Inc. This authorization includes, x-rays, surgery, hospitalization, medication, and any treatment procedure deemed "lifesaving" by the physician. The provision will only be invoked if the participant is not responsive, and the emergency contact is unable to be reached.

Consent Signature:_____ **Date**:_____
(First parent/legal guardian OR Participant if 18 or older)

Consent Signature:_____ **Date**:_____
(Second parent/legal guardian)

Non-Consent

Consent is NOT given for emergency medical aid/treatment in the case of illness or injury during the process of receiving services or while on the property of Equine-Assisted Therapy, Inc. In the event emergency aid/treatment is required, I wish the following procedures to take place: _____

_____

Non-Consent Signature:_____ **Date**:_____
(First parent/legal guardian OR Participant if 18 or older)

Non-Consent Signature:_____ **Date**:_____
(Second parent/legal guardian)

Photo Release

In consideration for being accepted into Equine-Assisted Therapy, Inc. therapeutic programs and for the valuable benefits I receive from participating in the program and promoting the program, I _____hereby authorize Equine-Assisted Therapy, Inc. its advertising agencies or the news media to have photographs, films, or other audio-visual materials taken of the participant for promotional material, educational activities, exhibitions or for any other use for the benefit of Equine-Assisted Therapy, Inc. therapeutic program. **I hereby indemnify and hold Equine-Assisted therapy, Inc. harmless against any and all claims of damages arising out of the use of any such photographs or films of me or audio-visual materials containing the participants' image.**

Name:_____ **Signature:**_____ **Date:**_____
(First parent/legal guardian OR Participant if 18 or older)

Name: _____ **Signature**: _____ **Date**:_____
(Second parent/legal guardian)

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Equine-Assisted Therapy, Inc.

Participant Release and Indemnification Agreement

I acknowledge and understand the inherent risks of equine activities and that horsemanship experiences can result in injury and even death. In consideration for being accepted into the Equine- Assisted Therapy program and for the benefits I receive from participating in the program, I, _____, *(participant if 18 or older, or parent/legal guardian)* hereby consent to assume the risks of _____, (*participant*) participation in the horsemanship program sponsored by Equine-Assisted Therapy, Inc. I/we (*parent(s)/legal guardian(s)*) hereby consent to assume the risks of my/our participation in the horsemanship program sponsored by Equine-Assisted Therapy, Inc.

Accordingly, I hereby, intending to be legally bound for myself, my heirs, assigns, executors, and/or administrators, waive and forever release, acquit, discharge, and hold harmless, Equine-Assisted Therapy, Inc.; the owners of the facilities and properties on which Equine-Assisted Therapy, Inc. conducts its therapeutic and equine related programs and activities, including but not limited to, the City of Town and Country and the City of Wildwood Missouri; the officers, directors, agents, employees, representatives, therapists, instructors, and volunteers of Equine-Assisted Therapy, Inc.; and any other person(s) associated with Equine-Assisted Therapy, Inc. therapeutic and equine-related programs and activities, and the successors and assigns of each and all of the above mentioned parties, from all manner of claims, demands, and damages of every kind and nature whatsoever I may now or in the future have against these parities due to any loss or personal injury, physical or mental condition, whether known or unknown to myself, and the treatment thereof, as a result of, or in any way connected with Equine-Assisted Therapy, Inc. and equine-related programs or activities, ***or growing out of acts or omissions or caused by negligence or in any way incidental to Equine-Assisted Therapy, Inc. therapeutic and equine related programs and activities.*** I have asked or have had the opportunity to ask any and all questions that I may have relating to the risks involved in therapeutic and equine related programs and activities. I fully understand and accept these risks.

Name:_____ **Signature:**_____ **Date:**_____

(First parent/legal guardian OR Participant if 18 or older)

Name:_____ **Signature:**_____ **Date:**_____

(Second parent/legal guardian)

If at any time a litigation arises against Equine-Assisted Therapy, Inc. by party named as participant/legal guardian in this contract, they are responsible for all legal fees for all said parties.

Code of Conduct

Equine-Assisted Therapy, Inc. expects all employees, contract workers, team members, volunteers, and clients to treat each other and those whom they may encounter while representing EAT with respect and integrity. Inclusion is a vital tenant of our organization.

Anyone who displays behavior that could be detrimental to any of the parties listed above, or endanger them in any way, will be asked to leave the premises immediately.

This code of conduct also applies to our property, horses, and other animals.

Name:_____ **Signature:**_____ **Date:**_____

(First parent/legal guardian OR Participant if 18 or older)

Name:_____ **Signature:**_____ **Date:**_____

(Second parent/legal guardian)

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Equine-Assisted Therapy, Inc.

Participant Medical History and Physician's Statement

This form is valid for a period of 1 year from the date signed.

Participant Name:_____ **Date of Birth:**_____ **Age:**_____

Sex: Male - Female - Gender Neutral **Height:**_____ **Weight:**_____

Address:_____ **City:**_____ **Zip Code:**_____

Parent/Legal Guardian:_____

Participant Diagnosis:_____ **Date of onset:**_____

***** For persons with Downs Syndrome*****
***Negative Cervical x-ray for Atlantoaxial Instability**: Yes - No **Date of x-ray:**_____*
***Negative for clinical symptoms of Atlantoaxial Instability**: Yes - No*

Tetanus Shot: Date_____

Seizure: Type: _____ Controlled: _____ Date of last seizure: _____

Medications:_____

Mobility: Independent ambulation - Wheelchair - Cane - Walker - Crutches - Braces
Any special precautions_____

Please indicate if patient has a condition and/or surgery in any of the following and comment

Auditory:	Yes - No	**Comment:** _____
Visual:	Yes - No	**Comment:** _____
Speech:	Yes - No	**Comment:** _____
Cardiac:	Yes - No	**Comment:** _____
Circulatory:	Yes - No	**Comment:** _____
Pulmonary:	Yes - No	**Comment:** _____
Neurological:	Yes - No	**Comment:** _____
Muscular:	Yes - No	**Comment:** _____
Orthopedic:	Yes - No	**Comment:** _____
Allergies:	Yes - No	**Comment:** _____
Learning Disability:	Yes - No	**Comment:** _____
Mental Impairment:	Yes - No	**Comment:** _____
Psychological Impairment:	Yes - No	**Comment:** _____
Other:	Yes - No	**Comment:** _____

To my knowledge there is no reason why this person cannot participate in supervised equestrian activities. However, I understand that the therapeutic center 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, Psychologist, etc.) in the implementing of an effective equestrian program.

Physician name (please print):_____ **Phone:**_____

Physician Signature:_____ **Date:**_____

Address:_____ **City:**_____ **Zip:**_____

Equine-Assisted Therapy, Inc.

Credit Card Authorization Form

(To be filled out once you are given a class time)

Please complete all fields. You may cancel this authorization at any time by contacting us. This authorization will remain in effect until cancelled.

Credit Card Information
Card Type: ☐ MasterCard ☐ VISA ☐ Discover ☐ AMEX ☐ Other _____
Cardholder Name (as shown on card): _____
Card Number: _____
Expiration Date (mm/yy): _____CVV:_____
Cardholder ZIP Code (from credit card billing address): _____

I, _____, authorize *Equine-Assisted Therapy* to charge my credit card above for agreed upon purchases. I understand that my information will be saved to file for future transactions on my account. We will bill at the beginning of each session. If payment is not received by the beginning of the following session, we will charge your card on file and your lesson time will be given to another participant. If you cancel within 24 hours of your lesson, you will be charged for your class.

_____ _____

Customer Signature Date