Dear Prospective Chasing Rainbows Participant,

Thank you for your interest in Chasing Rainbows therapeutic horsemanship programs. Enclosed you will find general information on the application process and the required application paperwork. Please visit our website, www.chasingrainbow.org, for detailed program information.

The application process for the therapeutic horseback riding and family lesson programs are identical. Once all the completed forms have been received by our office, we will contact you in order to schedule a site visit and assessment. This assessment is free of charge and consists of introducing the participant to the horses and instructor and ensuring that the desired program option is the most suitable for the participant. We will then work with you to develop individualized goals and plans for the session.

**Please note that certain physical conditions are contraindicated to therapeutic riding and may prevent participation in our riding program. Please refer to our Policies for Participation posted on our website for more detailed information on our eligibility guidelines.*

Our programs run in 9-week sessions, with a one-hour lesson each week. Sessions occur in Spring, Summer, and Fall, as listed on the registration form. Attendance, makeup lessons, and payment policies are described in detail in our Policies for Participation, found on our website.

Should you have any questions concerning the application process, please call or email me at (717) 433-0768 or andrea@chasingrainbow.org.

Sincerely,
Andrea Gibson
Executive Director

Completed forms should be mailed to:
Chasing Rainbows
5621 River Rd.
Harrisburg, PA 17110

Application Checklist

Forms:

All forms must be completed, signed, and returned to Chasing Rainbows by the listed registration deadlines.

- ❑ Participant Application and Contact Information
- ❑ Consent for Release of Information (Optional; only needed if you plan to share any additional medical records with us)
- ❑ Authorization for Emergency Medical Treatment
- ❑ Functional History
- ❑ Liability and Media Release
- ❑ Medical History and Physician Statement (*To Be Completed by Participant's Physician)*

2017 Program Dates:

Spring Session:
Registration deadline: March 6
March 20 - May 19
Makeup week: May 22-26

Summer Session:
Registration deadline: May 22
June 5 - August 4
Makeup week: August 7-11

Fall Session:
Registration deadline: August 7
August 21 - October 20
Makeup week: October 23-27

Participant Information

Participant Information

Name:_____DOB:_____Age: _____

Height:_____**Weight**:_____

Address:_____City:_____State:____ZIP: _____

County of residence:_____Cell: _____

Parent/Guardian Name(s): _____

Weather cancellations will be announced via email. PLEASE LIST THE BEST EMAIL TO USE IN THESE INSTANCES, AND BE SURE TO CHECK YOUR EMAIL ON LESSON DAYS:

Email(s): _____

_____

Registration Information:

I would like to register for the following program(s): (Please circle all that apply):

Therapeutic Riding Family Lessons

I would like to register for the following session(s): (Please circle all that apply):

Spring 2017 Summer 2017 Fall 2017

Payment Information: (Please check the option that applies):

_____ I plan to secure or have secured alternative funding from:_____
Must be confirmed prior to registration deadlines in order to secure lesson time

_____ I have enclosed my Chasing Rainbows Scholarship application

_____ I plan to pay privately

For private pay participants registering for ALL THREE sessions only:
_____ I would like to register for the Payment Plan of $105 per month for 9 months. Payment due the 1st of the month, February - October.

Consent for Release of Information

I hereby authorize: _____

(agency, facility, professional, school, etc.)

to release information from the records of:_____DOB: _____

(participant name)

The information is to be released to: CHASING RAINBOWS for the purpose of developing an equine activity program for the above named participant. The information to be released is indicated below.

_____ Medical History

_____ Physical Therapy evaluation, assessment, and program plan

_____ Occupational Therapy evaluation, assessment, and program plan

_____ Speech Therapy evaluation, assessment and program plan

_____ Mental Health diagnosis and treatment plan

_____ Individual Habilitation Plan (I.E.P.)

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

_____ Psychosocial evaluation, assessment and program plan

_____ Cognitive-Behavioral Management Plan

_____ Other: _____

This release is valid for one year and can be revoked, in writing, at my request.

Signature:_____Date: _____

Print Name: _____

Relation to Participant: _____

Please send materials to:

Chasing Rainbows
5621 River Rd.
Harrisburg, PA 17110

Authorization for Emergency Medical Treatment

Name:_____DOB:_____Phone: _____

Address:_____City:_____State:_____ZIP: _____

Physician:_____Preferred Medical Facility: _____

Health Insurance Company:_____Policy #: _____

Allergies to medications: _____

Current medications: _____

In the event of an emergency, contact:

Name:_____Relation:_____Phone: _____

Name:_____Relation:_____Phone: _____

Name:_____Relation:_____Phone: _____

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 Chasing Rainbows, I authorize Chasing Rainbows to: 1. Secure and retain medical treatment and transportation as needed

2. Release client records upon request to the authorized Individual or agency involved in the medical emergency treatment.

CONSENT PLAN

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 person(s) above is unable to be reached.

Consent Signature:_____Date: _____

(Parent or 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 CHASING RAINBOWS. PARENT OR LEGAL GUARDIAN **MUST** REMAIN ON SITE AT ALL TIMES DURING EQUINE ASSISTED ACTIVITIES.

Non-Consent Signature:_____Date: _____

(Parent or legal guardian)

Functional History

Name: _____

Diagnosis: _____

MOBILITY (Check activity the participant is able to do)

❑ Walk unassisted for more than 10 minutes ❑ Walk unassisted for 10 minutes or less

❑ Walk with crutches ❑ Stand unassisted

❑ Stand with crutches ❑ Use a wheelchair (❑ Manual ❑ Power)

Special Notes or Concerns: _____

_____

SOCIAL FUNCTION (Check all that apply)

❑ Communicates Verbally

❑ Communicates Non-verbally using: _____

❑ Easily agitated

❑ Easily distracted

❑ Has pet(s)

❑ Has a fear of animals

❑ Tends to be introverted

❑ Tends to be extroverted

Special Notes or Concerns: _____

_____

GOALS: (*Why are you applying for participation? What would you like to accomplish?)*

_____

_____

_____

Release of Liability

_____ (participant's name) would like to participate in CHASING RAINBOWS' program. I acknowledge the risks and potential for risks of horseback riding. However, I feel that the possible benefits to myself/my son/ my daughter/my ward are greater than the risk assumed. I hereby, intending to be legal bound, for myself, my heirs and assigns, executors or administrators, waive and release forever all claims for damages against CHASING RAINBOWS, its Board of Directors, Instructors, Therapists, Aides, Volunteers, and/ or Staff for any and all injuries and/or losses I/my son/my daughter/my ward may sustain while participating in any CHASING RAINBOWS programs.

Signature:_____Date: _____

Media Release

I

____DO

___DO NOT

consent to and authorize the use and reproduction by Chasing Rainbows of any and all photographs and any other audio/visual materials taken of me/my son/my daughter/my ward for promotional material, educational activities, exhibitions or for any other use for the benefit of the program.

Signature:_____ Date: _____

Chasing Rainbows

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.

Medical History and Physician Statement

Participant:_____DOB: _____
Height:_____Weight: _____
Address:_____City:_____State: ZIP: _____
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/needs: _____
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: + -
Neurological Symptoms of Atlanto Axial Instability: _____

Please indicate current or past special needs 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			

Please note that the following conditions may suggest precautions and/or contraindications to equine activities. Please note whether these conditions are present.

Orthopedic
❑Atlantoaxial Instability – include neurological symptoms
❑Coxarthrosis
❑Cranial Defects
❑Heterotopic Ossification/Myositis Ossificans
❑Joint subluxation/dislocation
❑Osteoporosis
❑Pathologic Fractures
❑Spinal oint Fusion/Fixation
❑Spinal oint Instability/Abnormalities

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

Other
❑Indwelling Catheters/Medical Equipment
❑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 Setting
❑Heart Condition
❑Hemophilia
❑Medical Instability
❑Migraines
❑PVD
❑Respiratory Compromise
❑Recent Surgeries
❑Substance Abuse
❑Thought Control Disorder
❑Weight Control Disorder

Special Notes: _____
_____
_____
_____

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

Sincerely,

Andrea Gibson
Executive Director

Chasing Rainbows
5621 River Rd.
Harrisburg, PA 17110
(717) 433-0768

To my knowledge, there is no reason why this person cannot participate in supervised equine activities.

Physician Name:_____ MD DO NP PA Other: _____
Signature:_____ Date: _____
Address: _____
Phone:_____ License/UPIN Number: _____