Back In The Saddle Equine Therapy Center

334 College Hill Rd. / Hopkinton, NH 03229
(603) 746-5681 fax: (603) 746-3522
bitsetc2003@aol.com
www.bitsetc.org

2012 Programs at BITS ETC

Hello to all BITS ETC Riders,

Thank you for your interest in our 2012 programs. We offer therapeutic riding on Monday, Wednesday and Friday. The SpiritHorse Autism Intervention is offered Wednesday and Thursday. Our Weekend Warriors program is Tuesday, Thursday and Saturday. Vocational Education is offered by appointment, throughout the year.

You may download an application from our website for any of the above programs. Once complete, with medical clearance if required, your class time is reserved with the payment of one month of lessons/activities in advance.

Pages 3, 4 and 5 of the application for riding should be removed and given to your doctor for him/her to return to BITS ETC. These forms may be faxed to our secure fax at the number indicated above, or mailed to us at least one week before you wish to begin lessons.

Should you need to cancel your class we ask for 24 hours notice, if possible to cancel the instructor and any volunteers who come to support you. If we need to cancel a class it shall be noted on our phone message machine at the above number. Please call and check the message during inclement weather to determine if classes have been cancelled.

I look forward to seeing you all "back in the saddle!"

Best Regards,

Pauline Meridien

Director, BITS ETC

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REGISTRATION FORM

Participant Name_____

Primary Contact_____Phone_____

Address_____E-Mail_____

Age_____ Height_____ Weight_____

I wish to register for the following program:

_____Therapeutic Riding
_____SpiritHorse Autism Intervention
_____Equine Guided Education—Journey of the Spirit Horse
_____Vocational Education Secondary School
_____Vocational Education (Peer Supported)
_____Peer Supported Volunteer Training

I understand that when all required paperwork has been received (medical clearances) BITS ETC shall contact me to schedule a preliminary visit to establish suitability and schedules.

PHOTO RELEASE:

I ❑ DO ❑ **DO NOT** consent and authorize the taking and use / reproduction of any and all photographs, and or other audiovisual materials taken of me by BITS ETC for promotional, (printed, or web-based), exhibitions, educational activities, or for any other use for the benefit of BITS ETC.

_____ _____
Signature (Parent or Guardian if under 18) date

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Dear Health Care Provider:

Your patient:_____

(Participant's *Name*)

Is interested in participating in supervised equine 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 equine activities. Therefore, when completing this form, please note whether these conditions are present, and to what degree.

Orthopedic

Atlantoaxial Instability-include neurologic Symptoms
Coxa Arthrosis
Cranial Deficits
Heterotopic Ossification/Myositis Ossificans
Joint subluxation/dislocation
Osteoporosis
Pathologic Fractures
Spinal Joint Fusion/Fixation
Spinal Joint Instability/Abnormality

Neurologic

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

Medical/Psychological

Allergies
Animal Abuse
Cardiac Condition
Physical/Sexual/Emotional Abuse
Blood Pressure Control
Dangerous to self or others
Exacerbations of medical conditions(RA,MS)
Fire Settings
Hemophilia
Medical Instability
Migraines
PVD
Respiratory Compromise
Recent Surgeries
Substance Abuse
Thought Control Disorders

Other

Age under 4 years
Indwelling Catheters/Medical Equipment
Medications side-effects i.e. photosensitivity, fatigue
Poor Endurance
Skin breakdown (decubitus ulcers, etc)

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 BITS ETC at the above address/phone number.

PATICIPANT MEDICAL HISTORY AND PHYSICIAN STATEMENT

Participant _____DOB_____Height_____Weight_____
Address_____
Diagnosis_____Date pf 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: (circle one) Independent Ambulation Assisted Ambulation Wheelchair

Braces/Assistive Devices_____
For those with Down's Syndrome: AtlantoDens Interval X-Rays done _____ Result: _____
Neurologic 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			

Given the above diagnosis and medical information, this person is not medically precluded from participation in equine assisted activities. I understand that the NARHA center will weigh the medical information given against the existing precautions and contraindications. Therefore, I refer this person to BITS ETC for on-going evaluation to determine eligibility for participation.

Name _____MD DO NP PA Other_____

Signature_____ Date_____
Address_____
Phone ( )_____NPI #_____

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PARTICIPANT CONSENT FOR RELEASE OF INFORMATION

I hereby authorize _____

(***Healthcare Provider, School, Other Party***)

To share protected personal information with Back In The Saddle Equine Therapy Center, 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
- Mental Health diagnosis and treatment plan
- Individual Habilitation Plan (IHP)
- Classroom Individual Education Plan (IEP)
- 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_____

(**Parent or Guardian if under 18**)

Print Name_____

Relationship to Participant_____

Please fax information to Back In The Saddle Equine Therapy Center at secure fax# (603) 746-3522, or mail to 334 College Hill Rd., Hopkinton, NH 03229

RELEASE OF LIABILITY

Although every effort will be made to avoid accident or injury, NO LIABILITY can be accepted by BITS ETC, it's officers, board of directors, agents, employees, and any of its members, associates, or the property owners upon whose land the therapeutic riding sessions are conducted.

According to RSA 508:19:

"…an equine activity sponsor, an equine professional, or any other person engaged in an equine activity, shall not be liable for any injury or the death of a participant resulting from the inherent risks of equine activities and, except as provided in paragraph III of this section, no participant's representative shall made any claim against, maintain an action against, or recover from any other person for injury, loss, damage, or death of a participant resulting from any other inherent risks of equine activities. Each participant in an equine activity expressly assumes the risk of and legal responsibility for any injury, loss or damage to person or property which results from participation in an equine activity. Each participant shall have the sole responsibility for knowing the range of his or her ability to manage, care for, and control a particular equine or perform a particular equine activity, and it shall be the duty of each participant to act within the limits of the participant's own ability, to maintain reasonable control of the particular equine at all times while participating in an equine activity, to heed all posted warnings, and to refrain from acting in a manner which may cause or contribute to the injury of any person…"

I have read and understand the legal limits of liability of BITS ETC, and request to participate in therapeutic riding activities as a (**please initial**):

_____Student _____Volunteer _____Visitor/Clinic Participant

I understand the inherent risks and potential for risk of equine activities, and agree to accept them. 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 BITS ETC, its board of directors, instructors, therapists, aides, volunteers, and /or employees for any and all injuries and or losses I (my child, 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 Liability Release in its entirely; that he / she understands the terms of this release and has signed this release voluntarily and with full knowledge of the effects thereof.'

_____ _____

Participant (**Parent or Guardian if under 18 years old**) Date

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AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

❑ Participant ❑ Staff Member ❑ Volunteer

Name _____DOB_____ Phone_____

Address_____ Email _____

Preferred Medical Facility_____

Physician's Name_____Phone_____

Health Insurance Co ._____Policy #_____

Allergies to medications? _____

Current Medications_____

In the event of an emergency, contact:

Name_____Relation_____Phone_____

Name_____Relation_____Phone_____

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.

Date _____Consent Signature_____
Volunteer**, (Parent or Legal Guardian if under 18)**

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CONFIDENTIALITY POLICY

It is the policy of Back In The Saddle Equine Therapy Center to hold absolutely confidential all charts, and communications (oral or written) made by and between or about Therapeutic Riding Center staff, board, volunteers, and clients. It is required that all staff, board members, and volunteers sign this confidentiality agreement. All of these persons are accountable for maintaining the confidentiality of therapy which occurs at BITS ETC. BITS ETC shall treat all communications regarding therapy as protected health information, and will be guided by the Federal Health Insurance Portability and Accountability Act (HIPAA) in all dealings with outside agencies, or interested persons.

Confidential Communication is any information that is either written or spoken, and shared between client, and / or family-guardian, and staff, volunteers, and board of directors in the course of service delivery of Equine Assisted Therapy and Equine Assisted Learning activities at BITS ETC. The information that is exchanged is considered confidential and is to be kept as such by all involved, and disclosed only to those people who are:

1. Present at the time the information is shared and working to further the interests of the client.
2. Working for BITS ETC, maintaining records of clients for informational purposes (i.e.) to aid in evaluation, and facilitating communications between staff/ volunteers, as well as for medical and psychological documentation.
3. Not associated with BITS ETC, but working on behalf of the client, such as an attorney, counselor, housing worker, or other social service agent.

Maintenance of Records:

1. BITS ETC maintains all records in a strictly confidential manner. Only staff members have access to these records. Clients/guardians may access their records at any time, and copies are available for a nominal copying fee.
2. In cases where information must be disclosed to others, BITS ETC must have a signed release form on file from the client or guardian before said information is disclosed.

CONFIDENTIALITY POLICY **(continued)**

Exceptions for the Release of Information:

1. Where a staff member or volunteer has reason to suspect a person has been either physically or sexually abused, a report must be made to the appropriate authority. If a volunteer suspects abuse, they should notify a staff member who will be responsible for reporting such. If the client is willing to report the abuse themselves, BITS ETC will have complied with the requirements for reporting. If they assist that individual with making the report.
2. In criminal proceedings, when the court has determined, through the procedure explained in RSA 173-c, that the information contained in the record or testimony is admissible under chapter 173-c, where medical emergency exists and the information from the file is required and the client/family/guardian is unable to authorize the release, information limited to the medical emergency will be **disclosed to any emergency personnel, and / or the medical institution treating the client.**

I _____have read and agree to abide by the confidentiality policy of BITS ETC.

_____ _____

Volunteer/ Staff Member / Client-Guardian **date**

_____ _____

Witness **date**