Back In The Saddle Equine Therapy Center

334 College Hill Rd. Hopkinton, NH 03229
Phone: (603) 746-5681 fax: (60) 746-3522
www.bitsetc.us bitsetc2003@aol.com

Welcome to BITS' Ride UP Programs for Veterans and Uniformed Professionals. This packet contains information on our various programs, and an application form which when completed will begin your journey in therapeutic riding and/or equine guided interactions.

Pages 3 through 6 of your application packet are to be filled out by your medical professional, so we may determine if there is any contra-indication to participation in this program. We offer interventions to people with physical, mental and emotional issues which may require special accommodations to participate in a safe manner. Safety is the primary concern at BITS, and as such, medical clearance is required before riding.

Therapeutic Riding

This eight-week program is offered once a week for one hour. We provide safety helmets, but ask that you come prepared to work outside, in layers for your comfort, and wear a hard-soled shoe/boot with a heel to protect your feet. You might also want sun screen and bug spray, and a hat for shade. No need to have prior horse experience; we provide education on horsemanship, ground work, training, and general horse care as well as riding.

Voc-Ed/Work Hardening Program

This program is offered once a week for two hours. In conjunction with NH Voc-Rehab, National A.B.L.E. network, Manchester VA and others, our campus provides work hardening skills as well as resume-building opportunities based on the jobs necessary to keep a herd of horses happy and healthy through the four seasons of New England weather.

A Little bit of BITS

A one-time group event, with instruction in horse handling, from the ground and astride. This is a morning or afternoon of immersion with horses. For groups of 10 to 20 people.

Thank you for your interest in BITS. We hope your time here is enjoyable, and helpful in getting you "back in the saddle."

Pauline Meridien
Director, BITS ETC

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REGISTRATION FORM

Participant Name____

Primary Contact______________________________Phone_______________

Address____

Town_________________________ZIP__________

E-Mail________________________________

Age_______ Height__________ Weight__________

Previous Horse Experience____

I wish to register for:

- ❑ Ride UP eight- week session
- ❑ Voc-Ed/Work Hardening
- ❑ A Little bit of BITS

PHOTO RELEASE:

I ❑ DO ❑ **DO NOT** consent to 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 date

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PARTICIPANT CONSENT FOR RELEASE OF INFORMATION

I ____

(***Participant***)

Hereby authorize ____

(Healthcare Provider)

To share protected personal information with Back In The Saddle Equine Therapy Center, for the purpose of developing an equine activity program. The information to be released is indicated below:

- ❑ Medical History
- ❑ Physical Therapy evaluation, assessment and program plan
- ❑ Occupational Therapy evaluation, assessment and program plan
- ❑ Psychosocial Evaluation, assessment and program plan
- ❑ Mental Health diagnosis and treatment plan
- ❑ Other ______________________________

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

Signature____Date__________

Print Name____

Please return information to Back In The Saddle Equine Therapy Center either by:

Secure fax# (603) 746-3522,

Or mail to: 334 College Hill Road, Hopkinton, NH 03229

603-746-5681
www.bitsetc.org

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

Cranial Deficits / TB
Osteoporosis
Pathologic Fractures
Spinal / Joint Instability

Neurologic

Seizures
Sensory Deficits

Medical/Psychological

Cardiac Condition
Physical/Sexual/Emotional Abuse
Blood Pressure Control
Dangerous to self or others
Thought Control Disorders
Migraines
Respiratory Compromise
Recent Surgeries
Substance Abuse

Other

Allergies, especially to hay, dust, animal dander
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.

PARTICIPANT MEDICAL HISTORY AND PHYSICIAN STATEMENT

Participant ___________________________________DOB__________Height_______Weight_________
Address____
Diagnosis ____ Date of Onset___________________
Past/Prospective Surgeries____
Medications____
Special Precautions / Needs ____
____

Mobility: (circle one) Independent Ambulation Assisted Ambulation Wheelchair

Braces/Assistive Devices____

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			
Immunologic			
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 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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EQUINE GUIDED INTERVENTION REFERRAL FORM

Participant Name: ____

Address: ____

Provisional Diagnosis: ____

Specific Issues to address: ____

____

Current Treatment Goals:

____

____

Additional Information: ____

____

____

____

____ ____________________

Mental Health Professional date

____ ____________________

State Credentials/License # phone/fax

Please return to BITS ETC/ 334 College Hill Rd. / Hopkinton, NH. 03229

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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 the Ride UP Program for veterans and uniformed professionals.

I understand the inherent risks and potential for risk of equine activities, and agree to accept them. I hereby, intending to e 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 Name (Printed)

____ ____________________

Participant Signature date

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AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

Name ______________________________________DOB_____________ Phone_____________

Address____

Preferred Medical Facility____

Physician's Name____ Phone_____________

Health Insurance Co .________________________________Policy #_______________________

Medication allergies ____ ____

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 "lifesaving" by the physician. This provision will only be invoked if the person(s) above is unable to be reached.

____ ____________________

Consent signature date

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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.

I have read and understand that BITS ETC will protect my personal information.

____ ____________________

(*Signature of participant)* *(Date)*