Greenlock Therapeutic Riding Center

Participant's Application and Health History

GENERAL INFORMATION

Participant: ______________________________________Parent/Guardian: ____
DOB: ______________ Height: ____________Weight: __________Gender: M F
Address: ____
Email Address:____
Phone: _________________________Daytime phone (cell or work): ____
School/Employer: ____
Parent/legal Guardian: ____
Address (if different from above): ____
Funding source:
Self_________
Other (specify E.I. School system, etc.) ____________________________________

PLEASE NOTE: **Greenlock TRC does not bill ANY insurance carrier for therapy services rendered.**

HEALTH HISTORY

Medical Diagnosis: ____Date of Onset: _________________________

Please indicate current or past medical history, including surgeries/injuries

	Y	N	Comments
Vision			
Hearing			
Sensation			
Communication			
Heart			
Breathing			
Digestion			
Elimination			
Circulation			
Emotional/mental health			
Behavioral			
Pain			
Bone/joint			
Muscular			
Allergies			

Medications (including over-the-counter and prescription, with NAME, DOSE, FREQUENCY):
____
____
____
____

FUNCTIONAL ABILITIES

*Please describe abilities/difficulties **IN DETAIL** for the following areas, and indicate assistance required and/or adaptive equipment*

Does the participant:

Communication	Y	N	Comments
Imitate sounds after hearing them?			
Gesture appropriately to indicate yes, no, or want?			
Says or signs 0-9 words?			

Says or signs 10-24 words?			
Says or signs 25-100 words?			
Says or signs 100+ words?			
Use phrases of 2 words?			
Speak/sign in full sentences?			
Uses phrases/sentences containing but/or?			
Spontaneously relate experiences in detail?			
Express ideas in more than one way?			
Listen attentively to directions?			
Follow instructions requiring an action and an object?			
Point accurately to one or more body parts?			
Indicate a preference when given a choice?			
Follow instructions with multiple parts?			
Recite all letters of the alphabet?			
Print or write name?			
Demonstrate understanding of the function of money?			
Daily Living Skills	Y	N	Comments
Indicate anticipation of feeding on seeing bottle or food?			
Eat solid food?			
Drink from bottle/cup/glass unassisted?			
Feed self with a spoon or fork?			
Demonstrate that hot things are dangerous?			
Look both ways before crossing a road/street?			
Indicate wet diapers?			
Indicated soiled diapers?			
Urinate in potty-chair or toilet?			
Defecate in potty-chair or toilet?			
Toilet trained during the day?			
Toilet trained during the night?			
Brush teeth without assistance?			
Cover mouth and nose when sneezing/coughing?			
Remove pieces of clothing without assistance?			
Put shoes on correct feet without assistance?			
Fasten all fasteners?			
Dress self completely?			
Put own possessions away when asked?			
Help with chores as asked?			
Demonstrate understanding of the clock?			
Socialization	Y	N	Comments
Respond to voice of caregiver?			
Show interest in novel objects or new people?			
Express two or more recognizable emotions like pleasure, fear, sadness or distress?			
Imitate simple adult movements like clapping or waving in response to a model?			
Play with toys or objects alone?			
Play with toys or objects with others?			
Play simple interaction games with others?			
Engage in make-believe activities alone?			
Engage in make-believe with others?			
Imitate adult phrases heard on previous occasions?			
Say please when asking for something?			

Label happiness, fear, sadness, and anger in self? In others?			
Share toys without being told to?			
Follow rules in simple games without being reminded?			
Have a preferred friend of the same sex?			
Follow school rules?			
Motor Skills	Y	N	Comments
Hold head erect for at least 15 seconds without assistance when held up in your arms?			
Sit unsupported for at least one minute?			
Raise self to sitting position?			
Move across the floor to get an object?			
Climb both in and out of a bed or a steady adult chair?			
Walk as the primary way of getting around?			
Self propel wheelchair in house? At school?			
Walk up and down the stairs?			
Run short distances?			
Jump with two feet?			
Jump over small objects?			
Hop on one foot while holding, without falling?			
Pedal tricycle at least 6 feet?			
Climb on high play equipment?			
Open doors that require only pushing or pulling?			
Transfer object from one hand to another?			
Pick up a small object with hands?			
Build with blocks, at least 5 high?			
Mark with pencil, crayon, and chalk on appropriate writing surface?			
Cut paper with scissors?			
Catch and throw a ball?			
Maladaptive Behavior	Y	N	Comments
Suck his/her thumb or fingers?			
Have poor concentration and attention?			
Demonstrate an over dependence?			
Often withdraw?			
Exhibit extreme anxiety?			
Have poor eye contact?			
Act impulsively?			
Have times of being overly active?			
Have temper tantrums?			

Please indicate all current therapies:

Occupational Therapy __ Speech Therapy__ Physical Therapy __

GOALS: (i.e. why are you applying for participation? What would you like to accomplish?)

____
____
____
______

PARENT/GUARDIAN
signature:____DATE:________________________

PHOTO RELEASE

I Do☐ *or* I Do Not☐ **Consent** to and **authorize the use** and reproduction by GREENLOCK THERAPEUTIC RIDING CENTER, INC. of any and all photographs and other audio/visual materials taken of me for promotional material, educational activities, exhibitions, or for any other use for the benefit of the program.

Signature:____Date:____
Participant/Legal Guardian/Parent

HIPPOTHERAPY SCHEDULING

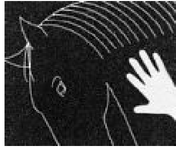
INFORMATION ON SCHEDULING:

- We will set up an assessment visit (necessary for ALL clients) **ONLY** if we have an open slot you can be scheduled in on a weekly basis. Please be as flexible as possible.
- Sessions run all year and are rain or shine. Dressing appropriately for weather conditions is extremely important.
- The more flexible you can be in scheduling time, the sooner we can schedule you in an open slot.
- There IS a waiting list for late day and Saturday slots.

These are the current hours we offer hippotherapy. Each appointment is ½ hour- the last appointment is ½ hour before closing. Please indicate in the box what day(s)/times you are available to attend a weekly ½ hour scheduled therapy session.

Monday 10:00 - 5:00	
Tuesday 10:00 - 5:00	
Wednesday 1:00 - 5:00	
Thursday 1:00 – 5:00	
Friday 10:00 – 5:00	

*********Weekend sessions only available to existing clients**********



Greenlock Therapeutic Riding Center
55 Summer Street, Rehoboth, MA 02769
508-252-5814 www.greenlock.org

Participant's Medical History & Physician's Statement

Participant: ____ DOB: _______ Height: ______ Weight: ____________

Address: ____ Home Phone Number: __________________

Diagnosis: _____________________________ICD 10 Code: ____________________________ 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: ____

Neurological Symptoms of AtlantoAxial 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			
Neurological			
Muscular			
Balance			
Orthopedic			
Allergies			
Learning Disability			
Cognitive			
Emotional/Psychological			
Pain			
Other			

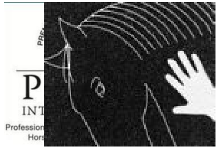
To my knowledge, there is no reason why this person cannot participate in supervised equestrian activities. However, I understand that the PATH center will weigh the medical information above against the existing precautions and contraindications. I concur with a review of this person's abilities/limitations by a licensed/credentialed health professional (e.g. PT, OT, SLP, Psychologist, etc.) in the implementation of an effective equine activity program. **I prescribe therapy for this participant.**

Name/Title: ____ MD____ DO____ NP____ PA____ Other __________

Signature: ____ Date: ____________________

Address: ____

Phone: ( )________________________________ License/UPIN Number: ___________________________



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Liability Release

Participant______ Staff______ Volunteer______

WARNING: Under Massachusetts Law, an equine professional is not liable for any injury to, or the death of, a participant in equine activities resulting from the inherent risks of equine activities, pursuant to Chapter 128, Section 2D of the General Laws.

The undersigned, in consideration of the use in any manner of the facilities of Greenlock Therapeutic Riding Center, Inc. (GTRC), including, but not limited to, horseback riding and the receiving of instruction by the undersigned (and / or by _________________________________, a minor child of the undersigned), agree, for themselves (and for said child, if any), to irrevocably waive, release, discharge, and hold harmless GTRC, their owners, directors, officers, employees, and agents, all from and against any and all manner of claims, liability damages, and legal or other notions for loss of damage to personal property of the undersigned (and said child, if any) and personal injury to the undersigned (and said child, if any) which may occur by or through the use of said facilities.

The undersigned is fully aware of the inherent risk involved in dealing with horses; and understands and appreciates the size, strength, unpredictability, and sensitivity of the animal. The undersigned is further aware that equestrian-related activities can be extremely dangerous; that accidents involving horses are frequent, and that the condition of the land is often hazardous, and that the ground and footing is rarely perfect. The undersigned does voluntarily participate in or observe these activities with the knowledge and appreciation of the dangers of potentially bodily harm and hereby agrees to assume any and all risk for property damage including personal injury or death.

____(Participant/Staff/Volunteer name) would like to participate in Greenlock Therapeutic Riding Center's program. I acknowledge the risks of horseback riding; however, I hereby, intending to be legally bound, for myself, my heirs and assigns, executors or administrators, waive and release forever all claims for damages against Greenlock Therapeutic Riding Center, Inc., its Board of Directors, Instructors, Therapists, Aides, Volunteers and/or Employees for any and all injuries and/or losses I / my son / my daughter / my ward may sustain while participating in Greenlock Therapeutic Riding Center.

All volunteers and staff at GTRC must be fully covered by their own health insurance.

I have read Greenlock's "General Information and Rules" and agree to abide by the rules outlined in that document.

Signed: ____ Date: ______________________

Name: ____

Address: ____

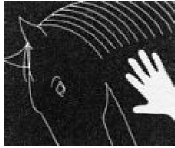
____

Phone: ____

Email Address: ____

Emergency contact name: ____________________________ phone number:____________________________

Health Insurance Company Name: ____



Greenlock Therapeutic Riding Center, Inc.
55 Summer Street, Rehoboth, Ma 02760
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Participant's Consent for Release of Information

I hereby authorize: Greenlock Therapeutic Riding Center, Inc.
☐ to release information to: physician; insurance carrier; or any Greenlock therapist for consultation purposes
☐ to obtain information from: physician____
(physician's name)

Pertinent to the person listed below:

Client:____ DOB: _____________________

____
(address) *(City, State, Zip Code)*
____
Diagnosis

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.H.P.)
. Classroom Individual Education Plan (I.E.P.)
. Psychosocial evaluation, assessment and program plan
. Cognitive-Behavioral Management Plan
. Other: ____

The released information will not be further transferred without additional authorization from me. I understand I may refuse to give consent to this release and that no service will be denied me because of such refusal.

Signature or Mark of Student:______________________________________ Witness to Mark:___________________________

If the person is a minor or has a guardian, a parent or legal guardian must sign this authorization.

Signature: ____ Date: ______________

Print Name: ____

Relation to Participant: ____

Please send materials to: ____

____

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DISCHARGE POLICY FOR GREENLOCK CLIENTS

Effective July 4th 2020

ATTENDANCE PROCEDURES:
Greenlock reserves the right to discontinue any client who fails to attend consecutively scheduled sessions. All clients may miss 12 sessions per year due to vacation, illness, surgery, or other activities. If a client misses more than the available 12 sessions, they will be removed from their slot and returned to the waiting list. Greenlock closures will not be included in this number.
All clients may retain a program slot for 2 years. After those 2 years, clients may choose to re-apply to the waitlist to be placed in a new slot. This policy is to ensure that as many people as possible can participate in therapy.
Clients/families are encouraged to discuss any anticipated attendance issues—such as inability to participate due to an upcoming surgery or extended vacation—with the Greenlock director so that this situation may be avoided if possible.

PROCEDURES FOR THERAPY CLIENTS ONLY:
If during one of the semi-annual evaluations the therapist determines that the client is no longer benefiting from therapy, the client will be discontinued. If therapeutic/recreational riding is appropriate, the client will be offered a possible slot. If the client is not appropriate for therapeutic riding, and therapy goals have been achieved, or the client has made no progress towards goals, the client will be discharged from therapy.

______________________________ ____________________
SIGNATURE OF PARENT/GUARDIAN **DATE**