UpReach Therapeutic Equestrian Center, Inc.
153 Paige Hill Road, Goffstown, NH 03045
603.497.2343 FAX: 603.497.5367

PARTICIPANT APPLICATION AND HEALTH HISTORY

(to be completed by the participant or parent/legal guardian)

PARTICIPANT INFORMATION

Legal Name: ______________________________________ Preferred Name: _____________________ DOB: ___________

Height: _____ Weight: _____ Gender: □ M □ F □ Non-Binary Pronouns: _______________________

Primary Diagnosis: ___________________________________ Secondary Diagnosis: __________________________________

Race: □ Asian □ Black/African American □ Hispanic/Latino □ White □ Other: ___________________________

Have you (or a member of your immediate family) ever served in the military? _____________________________________

Who does participant live with? (Self, parent/guardian, home care provider, etc.): ___________________________________

Address: ____ City: ____________________ State: _____ Zip: ________

Phone: ____________________________________ Email: ____

How did you hear about UpReach? ____

CONTACT INFORMATION

Parent/Legal Guardian (if different from participant): ____

Address: ____ City: ____________________ State: _____ Zip: ________

Phone: ____________________________________ Email: ____

Day Program Provider (if different from parent/guardian): ____

Phone: ____________________________________ Email: ____

In the event of an emergency and the parent/guardian is not available, please contact:

Name: ____________________________________ Relationship: ____________________ Phone: ______________________

PROGRAM PARTICIPATION

Would you like to: ____ Ride ____ Drive Participant □ is □ is not able to sit independently

What are your goals for therapeutic riding/driving? What would you like to accomplish? _____________________________

____

____

____

____

HEALTH HISTORY

Please indicate current or past concerns in the following areas:

	Yes	No	Comments
Vision			
Hearing			
Sensation			
Communication			
Heart			
Breathing			
Digestion			
Elimination			
Circulation			
Emotional/Mental Health			
Behavioral			
Pain			
Bone/Joint			
Muscular			
Thinking/Cognition			
Allergies			

MEDICATIONS *(include prescription, over-the-counter; name, dose and frequency) Attach additional sheet if needed.*

____

____

____

Please provide additional information in the following areas (include assistance required or equipment needed):
PHYSICAL FUNCTION *(i.e. mobility skills such as transfers, walking, wheelchair use, driving/bus riding)*

____

____

____

____

PSYCHO/SOCIAL FUNCTION *(i.e. work/school including grade completed, leisure interests, relationships- family structure, support systems, companion animals, fears/concerns, etc.)*

____

____

____

____

Signature: ____ Date: _______________

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Release of Liability and Indemnity Agreement

This release and waiver of liability and indemnity agreement is made and entered into on this ____ day of ____________, 20_____ by and between UpReach Therapeutic Equestrian Center Inc. (herein after referred to as the "farm") and____ (herein referred to as the "participant") and if the participant is a minor, participant's parent or legal guardian, ___________________________________, in return for the use today and on all future dates of the property, facilities, services, and horses of the farm, or the property, facilities and services of the farm if participant provides his/her own horse (as described below) the participant, his/her assigns, and legal representatives (collectively referred to as the "participant") hereby expressly agrees to the following:

1. The participant expressly acknowledges, understands, and agrees that the activities engaged in at the farm involves some inherent risk and involve the risk of serious injury and/or death and/or property damage.

2. The participant acknowledges, understands and agrees that the behavior and temperament of horses is unpredictable.

3. The participant attests that he/she does not have any physical condition or limitation that would prevent him/her from participating in the activities engaged in at the farm. It is the responsibility of the participant to carry full and complete insurance coverage on his/her horse, personal property and him/herself.

4. Participant agrees to assume full responsibility for any and all risks involved in or arising from participant's use of or presence upon the farm's property and facilities including, but not limited to, the risks of death, bodily injury, personal injury, property damage, falls, kicks, bites, collisions with vehicles, horses or stationary objects, fire or explosion, the availability of emergency medical care or the negligence of the farm or any agents, servants or employees thereof or another person.

5. Participant agrees to hold the farm and all of its successors, assigns, subsidiaries, franchises, affiliates, officers, directors, employees and agents complete harmless and not liable and hereby release, waive and discharge them from all liability whatsoever and agrees not to sue them on account of or in connection with any claims, causes of actions, injuries, damages, costs or expenses arising out of participants use of or presence upon the farm's property and facilities whether or not caused by the negligence of the farm, including claims for consequential damages.

6. Participant agrees to indemnify, and defend the farm against, and hold it harmless from any and all claims, causes of action, loss and liability, damages, judgments, settlements, costs or expenses, including attorney's fees, which in any way arise from or are caused in whole or in part by participants actions, inactions, participant's property and/or horse(s), family and/or guests use of or presence upon the farm's property and facilities, including any negligence on the part of the farm.

7. Participant agrees to abide by all of the farm's rules and regulations.

8. If participant is using his/her horse, the horse shall be free from infection contagious or transmissible disease. The farm reserves the right to refuse a participant to ride his/her horse on the farm's premises if the farm deems the horse is not in proper health or is deemed dangerous or undesirable.

9. This Release and Waiver of Liability and Indemnity Agreement is made and entered into in the State of New Hampshire and shall be enforced and interpreted under the laws of this state. Should any clause be in conflict with state law, then that clause shall not affect the validity of any other clause. When the farm and participant and participant's parent or legal guardian, if participant is a minor, sign this Release and Waiver of Liability and Indemnity Agreement, it will then be binding on both parties subject to the above terms and conditions.

The Undersigned has read and voluntarily signs the Release and Waiver of Liability and Indemnity Agreement and further agrees that no oral representations, statements or inducements apart from the foregoing written agreement have been made.

By: ____ Date: ___/____/__________
(Participant's Signature or Parent/Legal Guardian)

Print Name: ____

Address: ____

Phone: ___________________________

EMERGENCY CONTACT

Name: ____ Relationship: ________________

Address: ____

Phone: ___________________________

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CONFIDENTIALITY POLICY AND PROCEDURE

It is the policy of UpReach Therapeutic Equestrian Center, Inc. to hold absolutely confidential all UpReach documentation and communications (oral and written) made by and between or about UpReach Therapeutic Equestrian Center staff, participants, board, and volunteers.

It is required that all staff, board members, and volunteers sign a confidentiality agreement. All of these persons are accountable for maintaining the confidentiality policy.

Information will be disclosed only with the permission of the individual involved (for exceptions see IV).

I. Definition of Confidential Communications

Confidential Communication is any information that is either written or spoken, and shared between participant and/or family/guardian and staff, volunteers, and board in the course of service delivery and/or in the relationship. The information that is exchanged is considered confidential and it is to be kept as such by staff, volunteers, and board, and disclosed only to those people who are:

A. Present at the time the information is shared and working to further the interests of the clients.

B. Staff or appropriate assigned designees working for UpReach Therapeutic Equestrian Center,Inc. maintaining records of participants for informational purposes. Statements of evaluation or opinion are to be avoided.

C. Not associated with UpReach but working on behalf of the participant, such as attorney, counselor, housing worker, or other social service agent.

In cases where information is disclosed by UpReach, a signed release of information must be obtained by the participant, parent, or legal guardian prior to the release thereof.

II. Maintenance Records

UpReach Therapeutic Equestrian Center, Inc. maintains records of participants for informational purposes (i.e. to aid in evaluating program and facilitating communications between staff/volunteers).

III. Access to Records

A. Staff members and appropriate assigned designees have access to participant's records.

B. A participant's request to examine their files will always be honored. She/he also has the right to copies of their file.

IV. Release of Information

The participant, parent, or legal guardian makes the decision about all disclosures. She/He must sign a release of information form, detailing the information to be released, to whom and the purpose thereof. She/He has the right to revoke this consent at any time. This must be submitted in writing.

V. Exceptions for the Release of Information which do not Require Consent

A. Suspected Abuse that triggers mandatory reporting requirements under NH Law: If a volunteer suspects abuse, they should notify a staff member who will be responsible for reporting.

B. Criminal Proceedings: when the court had determined, through the procedure explained in RSA 173C,that the information contained in the record or testimony is admissible under Chapter 173-C.

C. Medical Emergency: where this exists and the information from the file is required and the participant/family/guardian is unable to authorize the release, information limited to the medical emergency will be disclosed to the medical institution treating the participant.

I, ____ have read and agree to abide by the confidentiality policy and procedures of UpReach Therapeutic Equestrian Center, Inc.

Signed: ____ Date: ___/____/__________

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PHOTO/VIDEO RELEASE

I hereby authorize the UpReach Therapeutic Equestrian Center, Inc. ("UpReach") to use my (or my child's/ward's) photographic or video image(s) in its web site, newsletter, or any other publication. UpReach may also distribute the image to newspapers, televisions or other media, including the internet, for use in advertisements, stories or news items pertaining to UpReach or its equine assisted programs.

I acknowledge that only UpReach is authorized to use the image(s). I am not giving my authorization for use of any image by any other organization, any other person or company. I understand that I may revoke this authorization at any time, except to the extent that action based on this authorization has already been taken, by submitting said revocation in writing and signed by me. I hereby release UpReach and its directors from any legal responsibility or liability for disclosure of the images.

If the person whose image is being used is under the age of 18, this authorization must be signed by a parent or guardian.

___ **DO** CONSENT TO USE OF IMAGES AS SET FORTH ABOVE

___ **DO NOT** CONSENT

Signature: ____ Date: ___/____/__________

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EMERGENCY MEDICAL AUTHORIZATION

Participant/Volunteer Name: ____

In the event that emergency medical/aid treatment is required due to illness or injury during participation in UpReach Therapeutic Equestrian Center, Inc. programs, I authorize UpReach Therapeutic Equestrian Center, Inc. as follows:

Consent

I authorize medical treatment including x-ray, surgery, hospitalization, medication, and any treatment procedure deemed 'life saving' by the physician. This provision will only be invoked if the person listed above is unable to be reached.

Consent Signature: ____ Date: ___/____/__________
(Parent or Legal Guardian, if under 18 or applicable)

Non Consent

I **do not** grant consent for emergency medical treatment/ aid in the case of illness or injury during the process of volunteering services or while on the premise of UpReach Therapeutic Equestrian Center, Inc. In the event emergency treatment is required, I wish the following procedures to take place:

____

____

Non-Consent Signature: ____ Date: ___/____/__________
(Parent or Legal Guardian, if under 18 or applicable)

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PARTICIPANT AVAILABILITY

Participant Name: ____ Date: ____/____/________

Please indicate all available times for riding or driving:

	Mon	Tues	Wed	Thurs	Fri
9:00 am					
10:00 am					
11:00 am					
12:00 am					
1:00 pm					
2:00 pm					
3:00 pm					
4:00 pm					
5:00 pm					
6:00 pm					

COVID-19 Acknowledgement of Risk & Acceptance of Services

Name: ____

Parent/Guardian Name (if applicable): ____

I am aware of the inherent risks of contracting COVID-19 while participating in services at UpReach Therapeutic Equestrian Center, Inc. and acknowledge that said organization is doing everything they can to protect the public, as well as its' staff, participants, volunteers and guests. I am aware that face-to-face services may increase my risk of contracting and passing on COVID-19 and agree to hold harmless UpReach Therapeutic Equestrian Center, Inc., its' staff, volunteers, and all others I may come in contact with during the time of services.
I agree to follow all guidelines and policies required by UpReach Therapeutic Equestrian Center, Inc. including but not limited to:

- Perform a self-health check prior to arrival and cancelling services if you are not feeling well.
- I have not traveled outside of the country or via methods requiring quarantine by the State of NH or I have followed the appropriate State of NH travel guidelines (copy available upon request).
- Follow UpReach Therapeutic Equestrian Center Inc.'s policies for protection, social distancing, and hand washing/sanitizing as provided. These policies will be updated as deemed necessary by the organization.
- Follow UpReach's policies regarding mask wearing and social distancing.
- Hand washing/sanitizing is expected upon entering and exiting the facility.
- Access only those areas of the facility open to the public.
- Please notify UpReach if you have tested positive for COVID-19 or have been in close contact with someone that has tested positive with COVID-19 to ensure compliance with UpReach COVID Guidelines.

UpReach will engage in regular cleaning and sanitizing of riding/driving equipment, grooming supplies, and frequently touched areas as needed.

UpReach reserves the right to dismiss anyone who is unable or unwilling to adhere to these protocols or if it is suspected they have been in contact with and/or are exhibiting symptoms of COVID-19.

I agree to follow these policies and hold harmless all individuals associated with my participation in activities at UpReach Therapeutic Equestrian Center, Inc.

____________________________________ ________________________________

Participant or Legal Guardian Signature Date

UpReach Therapeutic Equestrian Center, Inc.

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THERAPEUTIC RIDING AND DRIVING PROGRAM FEES

A $25 non-refundable administration fee is due with Therapeutic Riding or Therapeutic Driving participant application paperwork. **When you are scheduled, this fee will be applied towards your first invoice.**

UpReach Therapeutic Riding and Therapeutic Driving programs run in terms, which can be 6, 7, or 8 weeks in length. Please see the current program calendar (available at www.upreachtec.org) for upcoming term lengths. Term payment due dates are also listed on that calendar.

After you submit the paperwork and administrative fee, we will be in touch to confirm receipt and advise the next steps. You will not be billed for participation until scheduling has been confirmed.

- Therapeutic Riding lessons are typically 1-hour in length and cost $55 each.
  6-week term = $330, 7-week term = $385, 8-week term = $440

- Therapeutic Driving lessons are ½ hour in length and cost $40 each.
  6-week term = $240, 7-week term = $280, 8-week term = $320

Participant Name: ____

$25 application administration fee
Payment: Cash, Check, or credit card (VISA, MasterCard, Discover, or AmEx,) accepted

____ Cash   ____ Check (payable to: UpReach)   ____ Credit card

Cardholder Name: ____

Card Type: __ VISA   __ MasterCard   __ Discover   __ AmEx

Account #: ___________________________ Expiration Date: ____________ Security Code: ___________

Billing Address: ____

Authorized Signature: ____

FOR OFFICE USE ONLY:

Date: ____/____/_____ Amount Received: $ ___________ Check #: _______ Cash: $___________

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PARTICIPANT PHYSICIAN STATEMENT

Dear Health Care Provider:

Your patient, ________________________________, DOB: ____/____/_______, is interested in participating in supervised equine activities.

In order to safely provide this service, our center requires 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/Abnormalities

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

Other
Age – under 4 years
Indwelling Catheters/Medical Equipment
Medications – i.e. photosensitivity
Poor Endurance
Skin Breakdown

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

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 above.

Sincerely,

Lauren

Lauren Diener, Mounted Program Manager lauren@upreachtec.org

Participant's Medical History and Physician's Statement

Participant: ____ DOB: ____/_____/_______ Height: ___________ Weight: ___________

Address: ____

Diagnosis: ____ Date of Onset: ______/______/_______

Past/Prospective Surgeries: ____

Medications: ____

Seizure Type: _____________________________________ Controlled: ___ YES ___ N0 Date of Last Seizure: _____/______/_________

Shunt Present: ___ YES ___ N0 Date of last revision: ____/_____/______

Special Precautions/Needs: ____

____

Mobility: Independent Ambulation: ___ YES ___ N0 Assisted Ambulation: ___ YES ___ N0 Wheelchair: ___ YES ___ N0

Braces/Assistive Devices: ____

For those with Down Syndrome: AtlantoDens Interval X-rays, date: ____/_____/______ Result: **_____+ _____ --**

Neurologic Symptoms of AtlantoAxial Instability: ____

Please indicate current or past special needs in the following systems/areas, including surgeries:

	Yes	No	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 UpReach Therapeutic Equestrian Center will weigh the medical information given against the existing precautions and contraindications. Therefore, I refer this person to UpReach Therapeutic Equestrian Center for ongoing evaluation to determine eligibility for participation.

Name/Title: ____ ___ MD ___DO ___NP ___PA ___Other

Signature: ____ Date: ______/______/________

Address: ____

Phone: ______________________________ License/UPIN Number: ______________________ _______________