Calvin Center
Therapeutic Riding Program

Welcome!

Dear Parents, Participants or Caregivers,

Thank you for choosing Calvin Center. We look forward to working with you! Please read through all the information in this packer. It contains very important information regarding registration and participation on our programs.

Calvin Center's Equestrian Program is a 501(C)-3 whose mission is to provide Equine Assisted Services (EAS) for the community. As such, all programs rely heavily on community support in the form of monetary donations and volunteer hours. We offer a variety of equine based programming to include: Therapeutic riding (for those with cognitive, physical and /or emotional challenges), recreational riding (for those without any limitations), trail rides, and our Horses and Warrior Program, which is specifically dedicated to our US Veterans. We are a PATH Intl. (Professional Association for Therapeutic Horsemanship) Premiere Accredited Center, a Special Olympics Accredited Agency as well as an American Association for Horsemanship Safety approved facility. Quality of our programs and are participants' safety are of the utmost importance to us!

We are so excited that you are interested in joining the program and we can't wait to learn and grow with you. Welcome to the family!

Kate

Kate Robbins
Equestrian Director, Calvin Center
PATH Intl. Advanced Riding Instructor, CTRI
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www.calvincenter.org, kate@calvincenter.org

770-946-4276 (office)

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Calvin Center Equestrian Program Rider Application

Name: _____Date of Birth: _____/_____/_____ Age: __

Address: _____ City: _____ State: _____

Zip: _____

Home Phone: _____Business Phone:_____Cell Phone:_____

Email Address:_____

Parent/guardian: _____ Parent Phone:_____

Emergency Contact: _____ Phone: _____

School:_____School Address:_____

What is the best way to contact you? (circle one) home phone cell phone work phone e-mail

Who should we contact regarding application, scheduling, cancellations, billings etc?:_____

Contact phone number: _____ Contact e-mail: _____
Participant's school program _____ Phone _____
Participant's special education case manager _____ Phone _____
Physician's name _____ Phone_____
Specialist physician's name _____ Phone _____
Specialist physician's name _____ Phone _____

Participant's Diagnosed or verified Disability: _____(primary) _____(secondary)

Weight: _____ Height: _____

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Verbal: yes no

Primary mode of communication: _____

Describe participant's abilities/difficulties with function (i.e. mobility skills such as transfers, walking, wheelchair use.) Include assistance required or equipment needed: _____

_____

Describe participant's social abilities/difficulties:

_____

_____

Has participant ridden before? If so, what type of riding?

_____

What interests, activities and hobbies does the applicant enjoy at home and/or school? _____

_____

_____

_____

Calvin Center Therapeutic Riding Program strives to meet a rider's individual goals. These may include recreation, education, etc. Please share goals for participating in this program: _____

_____

_____

Please describe any additional fears, issues or characteristics of the applicant that our staff and volunteers need to know in order to best serve the applicant: _____

_____

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PARTICIPANT'S HEALTH HISTORY:
Please fill out completely. Attach additional sheet of paper if necessary.
*Please indicate **current or past** problems in the following areas*
.

	Y	N	Comments
Vision			
Hearing			
Sensation			
Communication			
Heart			
Respiratory			
Digestion			
Elimination			
Circulation			
Emotional			
Behavioral			
Psychological			
Thinking/Cognition			
Pain			
Bone/Joint			
Muscular			
Allergies			

Please list any current medications participant is taking, dosage, times taken and reason for taking:
_____

_____

I certify that I have supplied this health history information and that to the best of my knowledge, it is up to date, legal and accurate.

SIGNATURE: _____ DATE _____

SIGNATURE OF PARENT/GUARDIAN: _____ DATE _____

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CODE OF CONDUCT:

The undersigned acknowledges that he/she has read the Calvin Center Equestrian Program Code of Conduct document in its entirety; that he/she understands and agrees to behavior in the manor outlined the Code of Conduct. (The Code of Conduct is available on the web at www.calvincenter.org/equestrian)

SIGNATURE: _____ DATE _____

SIGNATURE OF PARENT/GUARDIAN: _____ DATE _____

LIABILITY RELEASE:

WARNING Under Georgia Law, an equine activity sponsor or equine professional is not liable for an injury to or the death of a participant in equestrian activities resulting from the inherent risks of equine activities, pursuant to O.C.G.A.§4-12-3.

I, _____ (participant or parent/guardian of participant) hereby consent to the participation of _____ (participant) in any and all of the Calvin Center's Equestrian programs, including but not limited to therapeutic riding. I acknowledge the risks and potential for risks in riding and working with horses. However, I feel that the possible benefits to myself/my child/my ward and the clients I/he/she work with are greater than the risk assumed. Intending to be legally bound, for myself, my heirs and assigns, executors or administrators, I hereby assume all risks associated with the horses, horseback riding and the handling of animals and equipment. I waive and release forever all claims for damages of every kind and nature whatsoever against Calvin Center Inc., its board of directors, instructors, therapists, aides, volunteers, owners of horses leased to Calvin Center, and all representatives, successors, assigns and/or employees thereof for any and all injuries and or losses I/my child/ my ward may sustain while participating in Calvin Center's Equestrian Programs.

PHOTO/VIDEO RELEASE: ____ I consent to and authorize____ I do not consent to nor do I authorize

Calvin Center Inc. to use and reproduce any and all photographs and any other audiovisual materials taken of me/my child/my ward for promotional printed material, educational activities, or for any other use for the benefit of the program.

POLICY OF CONFIDENTIALITY: Confidentiality is defined as "told in secret or private relations; trusted." Any information in regard to the participants (clients) at the Calvin Center Equestrian Program must be held in strict confidentiality. It is critical that we respect each individual. Confidentiality is considered one of the most basic responsibilities of our facility. In failure to abide by this policy, the quality of the services we provide may diminish and result in legal ramifications. I have read and understand Calvin Center's Policy of Confidentiality and agree to abide by the same.

The undersigned acknowledges that he/she has read this application its entirety; that he/she understands the terms of this release and has signed this release voluntarily and with full knowledge of the effects thereof.

SIGNATURE: _____ DATE _____

SIGNATURE OF PARENT/GUARDIAN: _____ DATE _____

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Participant's Authorization for Emergency Medical Treatment Form

Please print. Use blue or black ink.

If participant is under the age of 18 years of age or dependent, form must be signed by parent/legal guardian where indicated.

Participant name_____ Date _____

Address _____

Parent /legal guardian name if participant is under the age of 18 or dependent:

_____

Home phone_____ Alternate phone_____

Date of birth _____

List three other contacts in case of emergency:

Name _____Relation _____ Phone _____
Name _____Relation _____ Phone_____
Name_____ Relation _____ Phone _____

Physician's name _____

Preferred medical facility _____

Health insurance company _____ Policy # _____

Name of primary insured on policy

_____

Participant's social security number

_____

Social security number of primary insured

_____

Allergies to medications (describe reaction)

_____

Other Allergies (environmental, food,
etc.)_____

Date of last tetanus shot: _____ Tuberculosis test + or -- Date:_____

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Recent hospitalizations, surgeries or other health concerns:

_____

_____

Please list current medications on the back of this sheet.

Consent for emergency medical treatment:

In the event emergency medical aid/treatment is required due to illness or injury during the process of volunteering, or while being on the property of the agency, I authorize Calvin Center/Presbytery of Greater Atlanta to secure and retain medical treatment and transport if needed and to release participant records upon request to the authorized individual or agency involved in the emergency medical treatment. 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.
Participant consent

Signature_____Date_____

Participant's parent or legal guardian signature if under 18 or dependent:

_____Date_____

Printed name of participant:

_____

Printed name of parent or legal guardian if under 18 or dependent:

_____

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Rider's Medical History and Physician's Statement

To be completed by applicant's physician. Please type or print. Use black or blue ink.

Applicant's Name _____ Date of Birth _____ Gender _____

Parent / Guardian _____

Address _____

City _____ State _____ Zip _____

Diagnosis _____ Age of onset _____

Height _____ Weight _____

Please list current and past special needs in the following areas by checking YES or NO. If YES, please include complete information, including surgical history, pertaining to the situation. Attach an additional page if needed.

SPECIAL NEED	YES	NO	IF YES, OR HISTORY OF, DESCRIBE
Auditory Impairment			
Attention Deficit / Hyperactivity			
Learning Disability			
Mental Impairment			
Psychological Impairment			
Speech Impairment			
Visual Impairment			Glasses / Contacts:
Allergies			Type of Reaction
Cardiac			
Circulatory			
Gastrointestinal Gastrostomy			
Pulmonary Asthma / COPD			
Neurological Hydrocephalus/ Shunt			
Balance Impairment			
Sensory Loss			
Hypertonicity			
Hypotonicity			
Urological			

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Incontinence			
Indwelling Catheter			
Muscular Contractures			
Skeletal Spinal Column Injury			
Subluxing or Dislocating Joints			
Laminectomy			
Spinal Fusion			
Scoliosis – Degree / Type / Brace/ Last X-Ray			
Spondylolisthesis			
Osteoporosis			
Heterotrophic Ossification			
Fractures			Location? Healed?
Other			

For Persons with Down Syndrome:

Cervical X-ray for Atlantoaxial Instability:

Positive_____Negative_____X-Ray Date_____

Current clinical exam on _____(date) reveals _____*no symptoms* of Atlantoaxial Instability.

Comments: _____

_____

Medications: (type, purpose, dose): _____

_____

_____

Seizure Type: _____ Controlled_____

Date of Last Seizure _____ Comments_____

Mobility Status:

Ambulatory: _____yes_____no Assistive Device: _____cane _____crutches _____walker

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Prosthetic/Orthotics: _____yes _____no If yes, please specify
_____ Please indicate special precautions: _____

IN MY OPINION, THE INDIVIDUAL NAMED ABOVE CAN PARTICIPATE IN SUPERVISED MOUNTED EQUESTRIAN ACTIVITIES. I HAVE REVIEWED THE LISTED PRECAUTIONS AND CONTRAINDICATIONS AND ANY DESCRIPTIVE MATERIALS ENCLOSED. THIS FORM IS VALID FOR ONE YEAR FROM THE DATE SIGNED.

Physician's Signature _____ Date _____

Physician's Name (Please Print) _____ UPIN or License # _____

Physician's Address _____City _____ State_____ Zip _____

Physician's Telephone Number _____

****Only signatures of MD's or DO's are accepted*

INFORMATION FOR PHYSICIANS

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 or other cervical instability – including neurologic symptoms
Activity limiting arthritis
Cranial Deficits
Heterotopic Ossification/Myositis Ossificans (activity limiting)
Joint subluxation/dislocation
Osteoporosis
Pathologic Fractures
Spinal Fusion/Fixation
Spinal Instability/Abnormalities

Medical/Psychological

Allergies
Animal Abuse
Physical/Sexual/Emotional Abuse
Blood Pressure Control
Dangerous to self or others
Exacerbations of medical conditions
Fire Settings
Hemophilia
Medical Instability
Migraines
PVD Respiratory Compromise
Recent Surgeries
Substance Abuse
Thought Control Disorders
Weight Control Disorder

Neurologic

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

Other

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Age – under 4 years'
Indwelling Catheters
Medications - photosensitivity, balance,
memory, dizziness, judgement
Poor endurance
Skin Breakdown

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Covid-19 Acknowledgement of Risk and Acceptance of Services

I, _____ (Participant Name), am aware of the risks of contracting Covid-19 while receiving face to face services from participating or volunteering at Calvin Center at this time of the pandemic outbreak and the Georgia Governor Kemp's shelter in place order as it applies to medically fragile and elderly citizens.

I am also aware that face to face services increase my risk of contracting and passing on the Covid-19 or Coronavirus and agree to hold harmless Calvin Center, its employees and all other individuals I may come in contact with during this interaction and receiving of services.

I agree to and will follow all guidelines for personal hygiene, personal safety and public safety as recommended or required by Calvin Center and my individual provider/practitioner. This may include, but is not limited to, waiting in my vehicle and/or home until I am asked to enter the barn premises either in person or via telephone; washing my hands prior to each session; use of hand sanitizer upon request; wiping down surfaces with disinfecting wipes and/or wearing a protective medical mask and/or gloves.

I agree to cancel my services should I have within the previous 24 hours to 2 weeks personally exhibited or have been in contact with someone who has presented with illness including cough, sneezing, fever, chest congestion or additional signs of potential spread of any virus or bacteria/disease. In addition, I will follow the recommendations of my provider once I have notified them of these risks in regard to my future services during this pandemic.

Calvin Center will engage in regular cleaning and sanitizing of horse tack, grooming supplies and office, doors, and frequently touched areas in-between clients and on a daily basis as recommended by the CDC and our contracted Veterinarian for the safety of clients, employees, volunteers and horses.

I am signing under my own free will and choice and agree to follow these and hold harmless all individuals associated with or through my services acquired from Calvin Center.

By signing below, I confirm that I am not considered a person at risk by the guidelines provided by the CDC and Georgia Department of Health.

Participant Name: _____Date: _____

Participant Signature:

_____

Parent/Guardian Name: _____Date: _____

Parent/Guardian Signature: _____