Compassionate Friends
Therapeutic Riding Center

40 Cooper Tomlinson Road
Medford, NJ 08055
(609) 320-5363
Fax (609) 953-4393
Email: sbriggs@cftrc.org

Welcome Packet

Dear Family,

Compassionate Friends Therapeutic Riding Center (CFTRC) would like to thank you for the interest you have shown in our program. We are excited about the prospect of working with you!

CFTRC is a nonprofit organization. Our mission, with help from the community, is to strengthen the body, mind and spirit of each person while fostering independence in a safe environment. Our program uses horses to provide therapeutic benefits to individuals with physical, mental, emotional, behavior and learning disabilities.

To participate in our program, please read, complete and return the following documents.

- Student's Application and Health History Form – completed by Parent/Guardian
- Program Policies and Practices - please read & sign acknowledgement
- Student's Authorization for Emergency Medical Treatment Form – completed by Parent/Guardian
- Student's Consent for Release of Information Form – completed by Parent/Guardian
- Student's Release Form – completed by Parent/Guardian
- Student's Medical History and Physician's Release Form – completed by Physician
- Student's Annual Medical History and Physician's Review Form – completed by Parent/Guardian and Physician
- Financial Assistance Program and Application – please read

If you have any questions please don't hesitate to call.

Sincerely,
Sherri Briggs
President and Program Director
Compassionate Friends Therapeutic Riding Center

PATH INTERNATIONAL
Professional Association of Therapeutic Horsemanship International

COMPASSIONATE FRIENDS
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Student's Application and Health History Form

Completed by Parent/Guardian

Date: _____

Name: _____ ☐ Male ☐ Female

Race/Ethnicity:
☐ Caucasian ☐ Black/African American ☐ Hispanic ☐ Asian ☐ Mixed: _____ ☐ Other: _____

Date of Birth: _____ Height. _____ Weight. _____

Home Phone: _____ Cell Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

E-mail address: _____

Best to communicate by: ☐ Home Phone ☐ Cell Phone ☐ Text ☐ E-mail

Parent(s)/Legal Guardian: _____ _____

Occupation(s): _____ _____

Place(s) of Employment: _____ _____

Siblings (names & ages): _____

Caregiver(s) name/address/phone: _____

_____

Doctor's name(s)/addresses/phone: _____

_____

Therapist's name(s)/addresses/phone: _____

_____

School/Education/Day Program: _____

_____

Physical Limitations: _____

_____

Intellectual Limitations: _____

_____

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Student's Application and Health History Form

(continued)

Completed by Parent/Guardian

Please answer the following questions:

1. How did you hear about Compassionate Friends? _____

_____

2. What are your expectations for the student in the program? _____

_____

3. Have there been any significant health or physical development changes in the student's condition within the past 6 months?

_____

_____

Diagnosis: _____ Date of onset: _____

Please indicate current or past special needs in the following area(s):

	Y	N	Comments
Vision			
Hearing			
Sensation			
Communication			
Heart			
Breathing			
Digestion			
Elimination			
Circulation			
Emotional/Mental Health			
Behavioral			
Pain			
Bone/Joint			
Muscular			
Thinking/Cognition			
Other			

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Student's Application and Health History Form

(continued)

Completed by Parent/Guardian

Returning Student: ☐ Yes ☐ No

Did the student previously participate in another therapeutic program: ☐ Yes ☐ No

If yes, where and for how long: _____

Medication(s): (please include prescription, over-the-counter, name, dose and frequency)

_____

_____

_____

Physical function: (mobility skills such as transfer, walking, wheelchair use, driving/bus riding, other)

_____

_____

_____

Psych/social function: (such as work/school including grade completed, interests, relationships, family structure, support systems, companion animals, fears/concerns, other)

_____

_____

_____

Signature of Parent/Guardian: _____ Date: _____

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Program Policies and Practices

Lesson Scheduling: Lessons are scheduled for the same day and time each week. While every effort is made to accommodate a student's preferred day and time for lessons, scheduling of lessons is determined by the availability of our staff, volunteers and horses.

Attendance: We understand that absences from lessons are sometimes unavoidable. Experience has taught us that students who consistently attend their lessons show greater improvement in the areas of physical stamina, balance, posture and coordination. If you are unable to attend a regularly scheduled lesson, notification must be made by contacting us at 609-320-5363 as soon as the absence is anticipated. If we are notified within the hour of your scheduled lesson that you are unable to attend, payment for the lesson will be due.

Timeliness: Lessons that start late result in a loss of valuable riding time. If we are not contacted prior to the starting time of your lesson, we will only be able to keep the horses and volunteers for 10 minutes beyond the lesson start time. We will try to reschedule your lesson however payment may still be due.

Cancellation: Lessons can be cancelled due to weather or for other reasons as determined by the program. Students will be contacted immediately upon the decision to cancel lessons.

Payment: Lessons are payable either in advance or on the day of the lesson. If you are unable to make prompt payment please contact us.

Attire: We will provide riding helmets, which are mandatory when riding. Should you have your own helmet, it will need to be ASTM, SEI-approved. Participants should dress weather appropriate and always wear long, non-slip, pants (no nylon pants please) even during the summer. Jackets and gloves are required for cold weather, as our indoor arena is not heated. Sturdy-soled boots or shoes with a small heel are required (we have a small selection of paddock boots for use by participants). Long hair should be tied back and dangling jewelry not worn. Clogs or sandals are not permitted around the horses.

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Program Policies and Practices

(continued)

1. Safety is our highest priority. Please observe all posted signs. Authorized individuals only on mounting block and ramp.
2. Confidentiality is also important. Private information regarding our staff, students, volunteers, visitors, families and our farm should be treated as confidential.
3. A parent/guardian, caregiver, instructor or volunteer must accompany students at all times. Please hold the hand of smaller children around our horses.
4. Student drop offs are not permitted.
5. Non-riding children are welcome to watch our students, however they are not permitted in areas where instruction is provided.
6. Eating and drinking while riding are not permitted – this includes chewing gum.
7. Please refrain from offering food to students without permission as they may have a medical condition.
8. Any conflicts should be handled immediately between the parties involved and staff. Please contact the Program Director if concerns are not being addressed or resolved.
9. The speed limit at Seafrá Farm is 5 mph. Please be aware of our animals.
10. Smoking, alcohol or illegal substances are not permitted anywhere on our farm.
11. For everyone's safety, please make sure cell phones are left behind or turned off. Unexpected noises may startle our horses.
12. Please leave pets at home.
13. Please behave calmly around our horses. Soft voices only and no running.
14. Do not feed the horses or other animals as hand feeding encourages biting. It is also important for the horses' health that we monitor everything they eat. Horse treats may only distributed by staff.
15. Remember to tidy up after yourself. This helps to keep our farm safe, neat and clean.

☐ I have read and understand all the CFTRC Program Policies and Practices as stated.

Signature of Parent/Guardian: _____ Date: _____

Thank you!

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Student's Authorization for Emergency Medical Treatment Form

Completed by Parent/Guardian

Name: _____ DOB: _____ Cell phone: _____

Address: _____

Physician's Name: _____ Preferred Medical Facility: _____

Health Insurance Company: _____ Policy #: _____

Student's diagnosis: _____

Allergies to medications: _____

Current medications: _____

_____

In the event of an emergency, contact:

Name: _____ Relation: _____ Cell phone: _____

Name: _____ Relation: _____ Cell phone: _____

Name: _____ Relation: _____ Cell phone: _____

Consent Plan

In the event emergency medical aid/treatment is required due to illness or injury during the process of receiving services, or while being on the property, I authorize Compassionate Friends Therapeutic Riding Center to:

1. Secure and retain medical treatment and transportation if needed.
2. Release student's records upon request to the authorized individual or agency involved in the medical emergency 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.

Signature of Parent/Guardian: _____ Date _____

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Student's Consent for Release of Information Form

Completed by Parent/Guardian

I hereby authorize: (person or facility) _____

to release information from the records of: (student's name) _____

DOB: _____

The information is to be released to: Compassionate Friends Therapeutic Riding Center for the purpose of developing an equine activity program for the above student. 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: _____

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

Signature of Parent/Guardian: _____ Date _____

Print Name: _____

Relation to Student: _____

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Student's Release Form

Completed by Parent/Guardian

We the parent(s)/guardian(s) of _____, hereby give our approval to his/her participation in any and all activities of Compassionate Friends Therapeutic Riding Center. We assume all risks and hazards incidental to such participation, including transportation to and from activities and we hereby waive, release, absolve, indemnify and agree to hold harmless the organizers, sponsors, supervisors, participants, corporation, its members, the premises, equipment manufacturers and persons transporting our son/daughter to and from Compassionate Friends Therapeutic Riding Center activities. We as parents or guardians realize and have informed our son/daughter that falls are common and that injuries can result. We accept the hazards of participation.

We consent to and authorize the use and reproduction by Compassionate Friends Therapeutic Riding Center of any and all photographs and any other audio/visual materials taken of the student for promotional material, educational activities, exhibitions or for any other use for the benefit of the program.

Signature of Parent/Guardian: _____ Date _____

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Student's Medical History and Physician's Release Form

Completed by Parent/Guardian

Date: _____

Dear Health Care Provider: _____

Your Patient, _____ is interested in participating in supervised equine activities. In order to safely provide this service, our program requests you complete/update the attached Medical History and Physician's Statement Form. Please note 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 Settings
- ☐ Hemophilia
- ☐ Medical Instability
- ☐ Migraines
- ☐ PVD
- ☐ Recent Surgeries
- ☐ Respiratory Compromise
- ☐ Substance Abuse
- ☐ Thought Control Disorders
- ☐ Weight Control Disorder

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 us.

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Student's Medical History and Physician's Release Form

(continued)

Completed by Student's Physician

Participant: _____ DOB: _____ Height: _____ Weight: _____

Address: _____

Diagnosis: _____ 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: _____

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:

	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			

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Student's Medical History and Physician's Release Form

(continued)

Completed by Student's Physician

Given the above diagnosis and medical information, this person is not medically precluded from participating in equine assisted activities and/or therapies. I understand that the PATH center will weigh the medical information given against the existing precautions and contraindications. Therefore, I refer this person to the PATH center for ongoing evaluation to determine eligibility for participation.

I have reviewed the attached medical history and release (student's name) _____ to participate in the Compassionate Friends Therapeutic Riding Center program. I am aware and permit my patient to actively participate in the following areas (please check all that apply):

- ☐ Sitting astride a horse
- ☐ Grooming horses
- ☐ Walking beside a horse
- ☐ Other equine related ground activities

For all Students with Down Syndrome – Please Note:

Due to the nature of Equine Assisted Activities and Therapies, PATH Intl. and Compassionate Friends require that all individuals diagnosed with Down Syndrome must have an annual certification from their physician that a physical examination reveals no sign of AAI or decrease in neurologic function:

1. Most recent cervical x-ray for: ☐ AAI ☐ Positive ☐ Negative X-ray date: _____
2. Annual neurologic/physical exam for AAI/decreased neurologic function ☐ Positive ☐ Negative

   Exam date: _____

Name/Title: _____ ☐ MD ☐ DO ☐ NP ☐ PA ☐ other _____

Signature: _____

Date: _____

Address: _____

Phone: _____

License/UPIN Number: _____

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Student's Annual Medical History and Physician's Review Form

Completed by Parent/Guardian

Please update and submit this form annually with the requested signatures.

Student's name: _____ Birth date: _____

Primary diagnosis: _____ ICD code: _____

Onset: (please check one) ☐ Birth ☐ Childhood ☐ Adolescence ☐ Adulthood

Secondary dx: _____ Tertiary dx: _____

Height: _____ Weight: _____ Date of most recent Tetanus shot: _____

Please list all current medications:

1. _____ taken for _____
2. _____ taken for _____
3. _____ taken for _____
4. _____ taken for _____

Please describe any special precautions needed including surgical devices or implants:

_____

_____

Signature of parent/Guardian: _____ Date: _____

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Financial Assistance Program

Financial assistance is available to students based upon their ability to pay and availability of funds at the time of application. Ability to pay will be determined by income level, as well as other contributing factors including medical costs. Availability of funds will depend upon the number of individuals requesting financial assistance each session in relation to funds raised annually for this purpose. These funds are raised through the efforts and generosity of CFTRC staff, volunteers, students' families and our partners; and we have an obligation to those contributors to use their dollars wisely and with accountability.

Assistance levels – amounts indicated are your contribution to the session:

- ☐ 25% Assistance - $416.00
- ☐ 50% Assistance - $278.00
- ☐ 75% Assistance - $139.00

We encourage all of our families to contribute to our program. Please indicate below how you would like to contribute:

- ☐ I will volunteer
- ☐ I will recruit volunteers
- ☐ I will participate in fundraising
- ☐ Other: _____

To be considered for financial assistance, please complete and return the accompanying Financial Assistance Application. Requests for financial assistance will be kept strictly confidential. You will be contacted in a timely manner with regard to the availability and amount of financial assistance for the upcoming riding session. The Board of Directors will have final authority to approve or deny any request for financial assistance.

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Financial Assistance Application

Please note: Applications and awards are for the current session only. If reapplying for an upcoming session, the Financial Assistance Application will need to be completed again. You only need to submit your most current tax forms. If you are reapplying, please contact the CFTRC office to see if we already have your most current tax forms on file.

☐ New Application ☐ Reapplying

Name of Applicant: _____

Address: _____

Phone (Home): _____ (Work) _____

Name of Student (if different from applicant): _____ Age of Student: _____

Diagnosis: _____

Is the Student receiving other financial aid? ☐ Yes ☐ No

If yes, what is the source of that aid? _____

How many members in your household? _____

Are there other household members with special needs? ☐ Yes ☐ No If yes, how many? _____

Describe any special financial circumstances that affect your ability to pay the program fees
(use back of form for more space, if necessary):

_____

_____

Please attach a copy of pages 1 & 2 of your most recent tax form. For your protection, please darken out your SSN.

I hereby certify that the information given above is true, accurate and complete to the best of my knowledge. I am aware that if any of the information I have provided is incorrect, my financial assistance may be terminated. I understand that submitting this application does not guarantee an award of financial assistance.

Signature of Parent/Guardian: _____ Date _____

Print Name: _____

Relation to Student: _____

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