Welcome to Manes & Motions Therapeutic Riding Center, Inc. We are a not-for-profit organization dedicated to improving the well-being of children and adults living with physical, cognitive and/or emotional special needs through the benefits of equine-assisted activities. Our commitment to excellence is demonstrated through our affiliation with Hospital for Special Care, and as a premier accredited center through the Professional Association of Therapeutic Horsemanship International (PATH Intl.).

Manes & Motions offers a variety of therapeutic riding and equine-assisted learning sessions year round. Classes may be individual or group and are staffed by PATH Intl. certified instructors. During each lesson, participants take part in a variety of equine-assisted activities designed to address identified goals and objectives in a supportive environment. We invite you to set up an appointment to visit our facility and view a session. Interested participants should follow the application process below:

- Complete and return the attached forms. (In compliance with PATH professional standards, and as noted on the medical form, individuals with Down Syndrome are required to have medical clearance from a licensed physician which includes a neurological exam that specially denies any symptoms consistent with atlantoaxial instability.).
- Include $20.00 Non-Refundable Application Fee with forms.
- Placement status will be discussed with each participant upon completion of the assessment.
- The semester’s tuition is required at time of enrollment in order to secure the participant’s placement.

Please understand that many factors weigh into the placement of a participant such as resources, schedule availability and the presence of certain medical and/or behavioral conditions. These aspects, along with others, help determine a participant’s ability to participate in the program in a safe and meaningful way.

For further information, please contact Manes & Motions at 860.685.0008. Again, thank you for your interest in our program and we look forward to meeting you.

Sincerely,

Jeanna Pellino
Program Coordinator
Dear Physician,

Your patient is interested in participating in supervised equine-assisted activities, which may include horseback riding. In order to determine the appropriateness and safely provide services, our center requires the completion of this form and the signed and dated physician statement on the reverse side.

Please note that the following conditions may suggest precautions and contraindications to therapeutic riding and equine assisted activities. Therefore, when completing this form, please note whether these conditions are present, and to what degree. For individuals with Down Syndrome, please attach most recent AtlantoDens Interval X-ray report.

**Orthopedic**
- Atlantoaxial Instability – include neurological symptoms
- Coxarthrosis
- Cranial Deficits
- Heterotopic Ossification/Myositis Ossificans
- 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
- Cardiac Conditions
- 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**
- Age – under 4 years
- Indwelling Catheters/medical equipment
- Medications, i.e., photosensitivity
- Poor Endurance, lack of trunk stability
- Skin Breakdown

Thank you very much for your assistance. If you have any questions or concerns regarding this patient’s participation in equine activities, please feel free to contact me at 860.685.0008.

Sincerely,

Jeanna Pellino
Program Coordinator

Please complete and mail to: 874 Millbrook Road, Middletown, CT 06457
Or fax to: 860-346-0436
Participant: __________________________________________  DOB: _________

Height: _____  Weight: _____

Address: ____________________________________________  City___________________  Zip _____________

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/Diet/Needs/Allergies: ________________________________________________________


Braces/Assistive Devices: _______________________________________________________________________

For Down Syndrome: attach most recent report for AtlantoDens Interval X-rays, date & result:  + /--

Neurologic Symptoms of Atlanto-axial Instability: ___________________________________________________

This participant is up-to-date on all the following routine childhood immunization:

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Y</th>
<th>N</th>
<th>Date:</th>
<th>Y</th>
<th>N</th>
<th>Date:</th>
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</thead>
<tbody>
<tr>
<td>Measles</td>
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<td>Rubella</td>
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<td>Tetanus</td>
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<td>Pertussis</td>
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<td>Polio</td>
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<td>Ditheriap</td>
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</table>

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

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<tr>
<th>System/Area</th>
<th>Y</th>
<th>N</th>
<th>Comments</th>
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</thead>
<tbody>
<tr>
<td>Auditory</td>
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<td>Visual</td>
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<td>Tactile Sensation</td>
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<td>Speech</td>
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<td>Pulmonary</td>
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<td>Neurologic</td>
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<td>Muscular</td>
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<td>Balance</td>
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<td>Orthopedic</td>
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<td>Allergies</td>
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<td>Learning Disability</td>
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<td>Cognitive</td>
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<td>Emotional/Psychological</td>
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<td>Pain</td>
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<td>Other</td>
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</table>

Given the above diagnosis and medical information, this individual is not medically precluded from participation in equine-assisted activities. I understand that Manes & Motions Therapeutic Riding Center, Inc. will weigh the medical information given against the existing precautions and contraindications, therefore, I refer this individual to Manes & Motions Therapeutic Riding Center, Inc. for ongoing assessment to determine eligibility for participation.

Name/Title: ____________________________________________________  MD  DO  NP  PA  Other: ___________________

Signature: __________________________________________________________  Date: _____________________________

Address: _____________________________________________________  __________________________________________

Phone: ___________________________________  ___________________  License/UPIN Number: _________________________
MANES & MOTIONS THERAPEUTIC RIDING CENTER, INC.
PARTICIPANT REGISTRATION & LIABILITY RELEASE FORM

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

Participant Name: ________________________________________ D.O.B. __________________ Age:__________
Weight: ________ Height: _______ Diagnosis/Disability:___________________________________________________
Street Address: ___________________ Town ___________________ Zip__________
Part. Home Phone: _________________________ Cell: ____________________ Email: __________________________
Parent/Guardian/Caregiver Name: ______________________________________________________________________
Billing address (if different from part.)___________________________________________________________________
School/ Institution Presently Attending: _______________________ How did you hear about us: ____________________

Demographic Information: As a not-for-profit, Manes & Motions Therapeutic Riding Center, Inc. (“Manes”) relies on
funding sources that require the following:
Please check:     Male ____ Female ____      Veteran:   Yes ____   No ____
Household Income: __ below $15,000  __ $15,000-24,999  __ $25,000-39,999  __$40,000-54,999 __$55, 000+
Ethnicity: __ Caucasian   __  African-American   __  Asian __Native American  __Hispanic ___________ Other

EMERGENCY INFORMATION:
Preferred Medical Facility: _________________________________________________________________________
Primary Emergency Contact: _________________________________ Relationship: ___________________________
Phone: (         ) ________________________ Alternate name &ph: _________________________________________
Health Ins. Co. _____________________________________Policy#________________________________________

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT CONSENT PLAN
In the event that emergency medical aid/treatment is required due to illness or injury during the process of receiving services, or
while being on the property of the agency, I authorize representatives of Manes to: Secure and retain medical treatment and
transportation, and release client 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) listed cannot be reached.
Date: ________________Consent Signature_________________________________________________________
Client, parent or legal guardian if participant is under 18 years of age

PHOTO & PR RELEASE (please check one) ___ I DO     ___  DO NOT
Consent to, and authorize the use and reproduction by Manes of any and all photographs and other audiovisual materials taken
of me, and or my name, for any promotional material, educational activities, and exhibitions, or for any other use for the benefit
of the center.
Date: ____________Signature: _________________________________________________________________
Client, parent or legal guardian if participant is under 18 years of age

LIABILITY RELEASE (Required):
(Required): _________________________ (Participant Name) would like to participate in activities
offered by Manes (the “Program”). I acknowledge the risks and potential for risks of horseback riding and equine activities.
However, I feel that the possible benefits to myself/my child/my ward are greater that the risk assumed. I understand and
acknowledge that I/my child/ward will not be entitled to participate in the Program or to occupy the premises where Manes
conducts the Program if I do not sign the liability release and waiver. Therefore I hereby, intending to be legally bound for
myself, my heirs and assigns, executors, and administrators, fully assume all risks of injury or death and agree to defend,
indemnify, hold harmless, and completely and unconditionally release and waive forever all claims for damages against, and I
agree not to sue, Manes, its Board of Directors, Instructors, Therapists, Aides, Volunteers, and/or Employees, Daniels Farm,
LLC and Robert Daniels and Carolyn Daniels (together the “Released Parties”) for any and all injuries and/or losses I/my
child/ward may sustain while participating in the Program even if due to the negligence of any of the Released Parties. The
undersigned acknowledges that he/she has read this Registration and Release in 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.
Date: _______________ Signature: ______________________________________________________________
(Client, parent or legal guardian if participant is under 18 years of age)

Return completed form to:  Manes & Motions, 874 Millbrook Road, Middletown, CT 06457
Completing the following information will allow us to develop equine-assisted activities that best serve our participants. Thank you.

Name: ____________________________________________________ DOB ___________________________

Please indicate the program(s) of interest:  Therapeutic Riding ___ Unmounted Horsemanship ___ Other: _________________________________________

Availability:  Day(s): ____________________________________ Times:___________________________

Disability (Please indicate primary & secondary if applicable) ____________________________________

Posture: _______________________________________________________________________________

Balance: _______________________________________________________________________________

Movement/Coordination __________________________________________________________________

General Attitude & Behavior _______________________________________________________________

Perceptual / Balance Problems ____________________________________________________________

Communication Methods/Challenges (verbal, sign, pictures) ____________________________________

Cognitive Abilities (age level, multi step directions) __________________________________________

What are your goals for participation? (skills, behavioral changes, physical improvements etc.)
_______________________________________________________________________________________
_______________________________________________________________________________________

Special considerations? (i.e. health, precautions, medications etc.) _____________________________
_______________________________________________________________________________________

Previous riding experience? ________________________________________________________________

Special interests, activities, music, motivators etc. _____________________________________________
_______________________________________________________________________________________

Comments / Suggestions: __________________________________________________________________
_______________________________________________________________________________________

Please return completed form to: Manes & Motions, 874 Millbrook Road, Middletown, CT 06457