HOSPITAL FOR SPECIAL CARE

Manes & Motions Therapeutic Riding Center

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

Jeanna Pellino
Program Coordinator

HOSPITAL FOR SPECIAL CARE

Manes & Motions Therapeutic Riding Center

A member of the Hospital for Special Care community

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

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

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

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

MANES & MOTIONS THERAPEUTIC RIDING CENTER, INC.
PARTICIPANT'S MEDICAL HISTORY & PHYSICIAN'S STATEMENT

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: _____
_____May participate in all activities May participate except for: _____
Mobility: Independent Ambulation? Y N Assisted Ambulation? Y N Wheelchair? Y N
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:

	Y	N	Date:		Y	N	Date:
Measles				Pertussis			
Rubella				Polio			
Tetanus				Ditheriap			

Please indicate current or past difficulties 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			

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 & LIBILITY 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

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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): _____ (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

MANES & MOTIONS THERAPEUTIC RIDING CENTER, INC.
PARTICIPANT QUESTIONNAIRE

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