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.).

Our services are offered year round, broken into four semesters winter, spring, summer and fall varying in length from seven to thirteen weeks. Classes may be individual or group and are staffed by PATH Intl. certified instructors with the assistance of trained volunteers. Based on the needs of each participant, we explore the benefits of the human-equine bond through mounted and/or unmounted lessons providing participants with opportunities to develop riding and horsemanship skills.

To apply for services, please follow the application process below:

- Complete and return the attached forms. (In compliance with PATH Intl. 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 Assessment Fee with forms.
- Schedule an assessment once all paperwork has been completed.
- 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 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 services and we look forward to meeting you.

Sincerely,

Sarah Castellani
Program Manager

Program: 874 Millbrook Road, Middletown, CT 06457 | 860-685-0008 | www.hfsc.org

Mail: 2150 Corbin Avenue, New Britain, CT 06053 | 860-685-0008 | www.hfsc.org

Dear Physician,

Your patient is interested in participating in supervised equine-assisted activities, which may include horseback riding. In order to safely provide this service, our operating center requests that you complete the Physician's Statement for Participation. Please note that the following conditions may suggest precautions and contraindications to therapeutic horseback 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

If you have any questions or concerns regarding this patient's participation in equine activities, please contact me at 860.685.0008.

Sincerely,

Sarah Castellani
Program Manger

Return completed form to 874 Millbrook Road, Middletown, CT 06457 or fax 860-346-0436

MANES & MOTIONS THERAPEUTIC RIDING CENTER
MEDICAL HISTORY AND PHYSICIAN'S STATEMENT (To be filled out by physician)

Participant Name: ____________________________________ Date of Birth:___/_____/_____

Address: ____ City____________________ Zip __________

Height: _____ Weight: ______ Male☐ Female ☐

Diagnosis/Disability: ____ 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/Allergies: ____

Mobility:
Independent Ambulation: ☐ Yes ☐ No
Assisted Ambulation: ☐ Yes ☐ No
Wheelchair: ☐ Yes ☐ No
Braces/Assistive Devices: _____________________

For Those With Down Syndrome:
AtlantoDens Interval X-Rays, Date: ____/______/______ Results: __________________________________
Neurologic Symptoms of AtlantoAxial Instability: ____

Immunizations

	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			
Pain			
Pulmonary			
Neurologic			
Muscular			
Balance			
Orthopedic			
Allergies			
Learning Disability			
Cognitive			
Emotional/Psychological			

I have examined the above-named individual and he/she does not present apparent clinical contraindications to participate in equine-assisted activities. I refer this individual to Manes & Motions for an assessment to determine eligibility for participation.

____
Signature of health care provider MD / DO / APRN / PA Date Signed Printed/Stamped Provider Name/Number

MANES & MOTIONS THERAPEUTIC RIDING CENTER, INC.
PARTICIPANT APPLICATION

GENERAL INFORMATION

Participant Name: ______________________________________ Date of Birth:___/_____/____

Parent/Legal Guardian: ____
(if participant is under 18 years or otherwise incapable of signing)

Address: ____ City____________________ Zip ___________

Home Phone: _____________________ Cell Phone: __________________ Email: ___________________

Check: ☐ Male ☐ Female Height: _____________ Weight:______________

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

Availability: Day(s): ___________________________________ Times:____________________________

EMERGENCY INFORMATION

Preferred Medical Facility: ____

Physician's Name: __________________________________ Phone: ______________________________

Allergies to Medications: ____

Current Medication(s): ____

Emergency Contacts:

Name: _________________________________ Relation:________________ Phone: (____)_________

Name: _________________________________ Relation:________________ Phone: (____)__________

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.

Signature:____ Date: ________
(parent or guardian if participant is under 18 years of age or incapable of signing

HEALTH INFORMATION

Primary Diagnosis: _______________________ Secondary Diagnosis: _______________________

Mobility:
Independent Ambulation: ☐ Yes ☐ No Assisted Ambulation: ☐ Yes ☐ No
Wheelchair: ☐ Yes ☐ No Braces/Assistive Devices: _____________________

Communication:
☐ Verbal ☐ Non-Verbal
Communication Tools: ☐ Sign Language ☐ Tablet ☐ Picture Board ☐ Other ____

Social Communication and Interaction (check all that apply)
☐ Repeats words or phrases verbatim

- ☐ Difficulty understanding simple questions or directions
- ☐ Difficulty recognizing nonverbal cues, such as facial expressions, body postures or tone of voice
- ☐ Sensitivity to light, sound or touch
- ☐ Lack of Facial Expression or Eye Contact
- ☐ Screaming/Loud Vocalization

Patterns of behavior (check all that apply)

- ☐ Performs repetitive movements such as rocking, spinning, hand flapping, finger flicking
- ☐ Performs behaviors that could cause harm to self or others such as biting, hitting or head-banging
  - ☐ Behavior Trigger(s) ____
  - ☐ Coping/soothing Strategies ____
- ☐ Difficulty with change
- ☐ Fixates on an object or activity with abnormal intensity or focus
- ☐ Fear(s) ____

Previous riding experience? Y or N
If yes tell us about your experience and what skills you are currently able to demonstrate:

____
____

Goals (reason for applying; what you would like to accomplish)

____
____

What types of things work best for the applicant in terms of rewards and motivation?

____
____

PHOTO RELEASE (please check one) ___ I DO ___ DO NOT
Consent to, and authorize the use and reproduction by Manes & Motions 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.

LIABILITY RELEASE (Required): _________________________ (Participant Name) would like to participate in activities offered by Manes (the "Program"). I acknowledge the risks and potential 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 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.

Signature: ____ Date: __________
(parent or guardian if participant is under 18 years of age or incapable of signing)