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.).

Open year-round, Manes & Motions offers individual and group lessons staffed by PATH Intl. certified instructors and 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).
- 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,

Valerie Zajac
Program Coordinator

HOSPITAL FOR SPECIAL CARE

Manes & Motions Therapeutic Riding Center

Dear Health Care Provider,

Your patient is interested in participating in supervised equine-assisted activities, which may include horseback riding. In order to safely provide this service, our center requests that you complete the attached Medical History and Physician's Statement form. 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.

**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,

Valerie Zajac
Program Coordinator

**Return completed form to 874 Millbrook Road, Middletown, CT 06457, email vzajac@hfsc.org or fax 860-346-0436.**

**MANES & MOTIONS THERAPEUTIC RIDING CENTER**
**PARTICIPANT 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**: Neurologic Symptoms of AtlantoAxial Instability: ☐ Yes ☐ No

**Please indicate current or past difficulties in the following systems/areas, including surgeries. These conditions may suggest precautions and contraindications to equine activities.**

| | Y | N | COMMENTS |
|---|---|---|---|
| Auditory | | | |
| Visual | | | |
| Tactile Sensation | | | |
| Speech | | | |
| Cardiac | | | |
| Circulatory | | | |
| Integumentary/Skin | | | |
| Pain | | | |
| Pulmonary | | | |
| Neurologic | | | |
| Muscular | | | |
| Balance | | | |
| Orthopedic | | | |
| Allergies | | | |
| Learning Disability | | | |
| Cognitive | | | |
| Emotional/Psychological | | | |

Given the above diagnosis and medical information, this person is not medically precluded from participation in therapeutic riding or equine-assisted services. I understand that Manes & Motions Therapeutic Riding Center will weigh the medical information given against the existing precautions and contraindications. Therefore, I refer this person to Manes & Motions Therapeutic Riding Center for ongoing evaluation to determine eligibility for participation.

Name/Title: _____ MD DO NP PA

Signature: _____ Date: _____

Address:_____

Phone: _____ License/UPIN 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 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
☐ Difficulty with change
☐ Fixates on an object or activity with abnormal intensity or focus
☐ Sensitivity to light, sound or touch
☐ Fear(s) _____
☐ Behavior Trigger(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?
_____

**RELEASE OF LIABILITY AND ASSUMPTION OF RISK**

The undersigned participant or parent/legal guardian of participant if participant is under the age of 18 or otherwise incapable of signing (hereafter referred to using "I", "me", or "my") will be participating in mounted and/or unmounted equine-assisted activities offered at Manes & Motions Therapeutic Riding Center, Inc. (the "Center") (the "Program"). I understand and agree that horseback riding and equine-assisted activities involves certain inherent risks, dangers and hazards that can result in serious personal injury or death. However, I feel that the possible benefits to myself are greater than the risk assumed. I understand and acknowledge that I will not be entitled to participate in the Program or to occupy the premises where the Center conducts the Program if I do not sign the liability release 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, the Center, its Board of Directors, instructors, therapists, aides, agents, volunteers, and/or employees, Daniels Farm, LLC and Robert Daniels and Carolyn Daniels (together the "Released Parties") from any and all injuries and/or losses I may sustain while participating in the Program even if due to the negligence of any of the Released Parties. I understand and agree to comply with all of the Center's rules, policies and guidelines and understand that my access to the Center may be revoked, restricted or suspended for failure to follow such rules, policies and guidelines.

The undersigned acknowledges that he/she has read this 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)**

**Center of Special Care, Inc.**
2150 Corbin Avenue
New Britain, CT 06053

# AUTHORIZATION TO USE AND DISCLOSE PHOTOGRAPHS/RECORDINGS AND RELATED PERSONAL INFORMATION OF:

**{CIRCLE ONE – EMPLOYEE or VOLUNTEER or VISITOR}**

If you do not consent write "DO NOT CONSENT" across the form and sign.

**Name: _____ Phone: _____**

**Address: _____**

I give full permission to Center of Special Care, Inc. ("CSC") to take and use photographs, digital images, audiovisual recordings of me and/or interview me for purposes of fundraising, publicity, marketing, advertising, media relations and publication of research/public health information, corporate reports, and education materials.

I understand that such photographs, digital images, audiovisual recordings, and information obtained during interviews may be used and disclosed in any format for internal and external publication, including radio, television, video, internet, social media and other forms of communication to the public. This includes my permission to use and disclose my personal information that is shared with CSC staff, and with journalists and representatives of the media during interviews to which I hereby agree to participate, and other facts that can be inferred from the interview, photograph, digital image or audiovisual recording.

Attorneys may be allowed by the Hospital to capture recordings, images or video in the course of representing a patient; to the extent that I may be asked to assist in the process, and in accordance with Hospital policy, I hereby give my permission for use and disclosure of such images and recordings of me for the purpose of hearings and administrative or judicial proceedings in which the patient is a participant.

My name may be used and disclosed as indicated below:
**____ Full Name ____ First Name only ____ Initials only ____ No Name or Initials**

I understand that neither I nor CSC will receive direct or indirect payment for the communication related to photos, recordings, interview or other information obtained under this Authorization. I expressly waive the right to any compensation whatsoever or right to control copying, reproduction, or distribution of any recordings, photographs, or information otherwise obtained in accordance with this Authorization.

I certify that I am over eighteen (18) years of age and have the legal right and authority to sign this form. I understand the meaning of this form, and I hereby release CSC and its respective agents, servants, employees, physicians, officers, directors, and consultants from any claim or liability whatsoever in connection with the taking, use or disclosure/publication of photographs, digital images, audiovisual recordings, and/or information obtained during interviews (including my personal information).

_____ _____ _____
Signature Printed Name Date

Relationship to subject: _____
(if subject is a minor under 18 years or otherwise incapable of signing)

Witness: (Only use if subject is physically unable to sign, but is able to give his/her authorization in accordance with this form):

_____ _____ _____
Witness Signature Printed Name Date

Form rev. 5-2010; 3-2013; 3/6/2014; 7/9/2015; 5/30/2018
"CSC" includes all affiliates and operating entities under CSC, including but not limited to Hospital for Special Care, Hospital for Special Care Foundation, Inc., HSC Community Services, Inc. and Manes & Motions Therapeutic Riding Center, Inc., including their respective employees and agents.