PATH INTERNATIONAL
Professional Association of Therapeutic Horsemanship International

LifeStriders
Therapeutic Riding Center

S11 W29667 Summit
Avenue (US HWY 18)
Waukesha, WI 53188

Phone: (262) 565-6124
Email: striders@lifestriders.org
www.lifestriders.org
Fax: 866.404.3105

Life By the Reins

Social Skills Group Application

Authorization for Emergency Medical Treatment Form

Name:

Date of Birth: Home Phone: Email:

Address: City: State: Zip:

Physician's Name: Medical Facility:

Health Insurance Company: Policy #: Primary insured DOB:

Allergies to medications:

Current Medications:

In the event of an emergency, contact:

Name: Relation: Phone:

Name: Relation: Phone:

Name: Relation: Phone:

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 of the agency, I authorize LifeStriders to:

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

Consent Plan
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.

Date: Consent Signature:

Client, Parent or Legal Guardian

PATH INTERNATIONAL
Professional Association of Therapeutic Horsemanship International

S11 W29667 Summit
Avenue (US HWY 18)
Waukesha, WI 53188

LifeStriders
Therapeutic Riding Center

Phone: (262) 565-6124
Email: striders@lifestriders.org
www.lifestriders.org
Fax: 866.404.3105

Life By the Reins

Social Skills Group Application

GENERAL INFORMATION

Participant: _____ ☐M ☐F

DOB: _____ Age: _____ Height:_____ Weight:_____ Veteran: ☐Y ☐N

Ethnicity: (For grant writing purposes) _____

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

Phone:_____Alternative Phone:_____ Email _____

Employer/School: _____

Grade: _____

Address: _____

Phone: _____

Parent/Legal Guardian: _____

Address (if different from above) _____

Phone: _____

Referral Source: _____

Contact Numbers: _____

How did you hear about the program?_____

PATH INTERNATIONAL
Professional Association of Therapeutic Horsemanship International

LifeStriders
Therapeutic Riding Center

S11 W29667 Summit
Avenue (US HWY 18)
Waukesha, WI 53188

Phone: (262) 565-6124
Email: striders@lifestriders.org
www.lifestriders.org
Fax: 866.404.3105

Primary Diagnosis:

Secondary Diagnosis:

HEALTH HISTORY

Please indicate current or past problems in the following areas:

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

What medications is your child/teen currently taking including over-the-counter medications? If prescribed medication, please list medication name, purpose, dosage, and time.

PATH INTERNATIONAL
Professional Association of Therapeutic Horsemanship International

LifeStriders
Therapeutic Riding Center

S11 W29667 Summit
Avenue (US HWY 18)
Waukesha, WI 53188

Phone: (262) 565-6124
Email: striders@lifestriders.org
www.lifestriders.org
Fax: 866.404.3105

What is your primary reason for enrolling you child/teen in Life By the Reins?

FUNCTION Describe your child/teens abilities/difficulties with communication and mobility skills.

SOCIAL (i.e. Work/school including grade completed, leisure interests, relationships-family structure, support systems, companion animals, fears/concerns, etc.) Also please describe your child/teens personality.

GOALS. What would like to accomplish within the first 8 week session? Prioritize at least three goals for Life By the Reins staff to concentrate on?

1.

2.

3.

What social areas is your child successful/comfortable with?

What social areas does your child struggle with?

PATH INTERNATIONAL
Professional Association of Therapeutic Horsemanship International

LifeStriders
Therapeutic Riding Center

S11 W29667 Summit
Avenue (US HWY 18)
Waukesha, WI 53188

Phone: (262) 565-6124
Email: striders@lifestriders.org
www.lifestriders.org
Fax: 866.404.3105

What triggers negative behaviors from your child or teen?

Does your child have sensitive subjects staff should be aware of?

What strategies work well to motivate your child?

How is the issue for which you are seeking treatment affecting the following areas of your life?

	No Effect	Little Effect	Some Effect	Significant Effect	Not Applicable
Friendships					
Family					
Job/School Performance					
Financial Situation					
Physical Health					
Mood					
Anxiety Levels/Nerves					
Ability to Concentrate					
Eating Habits					
Sleeping Habits					
Ability to form lasting					
Ability to Control Anger					
Other:					

PARENTS, would you be interested in participating in ONE parent support group throughout each eight week session at the same
time as your child's/teens social skills group? Yes No

Additional Comments:

PATH INTERNATIONAL
Professional Association of Therapeutic Horsemanship International

LifeStriders
Therapeutic Riding Center

S11 W29667 Summit
Avenue (US HWY 18)
Waukesha, WI 53188

Phone: (262) 565-6124
Email: striders@lifestriders.org
www.lifestriders.org
Fax: 866.404.3105

PARTICIPATION WAIVER AND GUEST LIABILITY RELEASE AGREEMENT

As a participant at LifeStriders Therapeutic Riding Center, I acknowledge the risks and potential risks of equine related activities. (Under the Wisconsin Equine Activity Civil Liability Act [WI Statute 895.481], each participant who engages in an equine activity expressly assumes the risks of engaging in and legal responsibility for injury, loss or damage to person or property resulting from the risk of equine activities) However, I feel that the possible benefits are greater than the risks assumed. I hereby, intending to be legally bound, for myself, my heirs, and assigns, executors or administrators, waive and release forever all claims for damages against LifeStriders, Inc., its Board of Directors, Advisors, Board, Action Committee, Instructors, Therapists, Aids, Volunteers, and/or employees for any and all injuries sustained while participating in the LifeStriders Therapeutic Riding Program. All Volunteers and guests (guests = participants, siblings, parents, other relatives, friends) entering LifeStriders premises understand that they will be in contact with animals, and assume the risk of injury, and that it is possible that I or my guest(s) be bitten, scratched, and/or otherwise injured while on LifeStriders premises. I also understand that I or my guest(s) may be exposed to equine and/or other animal illness and disease and that it is also possible that I or my guest(s) could indirectly expose other animals to such illness and disease. My signature to this liability release attests to my, and my guest(s) intent to hold harmless and release from all liability against LifeStriders Inc., its Board of Directors, instructors, therapists, volunteers, and or employees for any and all injuries and or losses I or my guest(s) may sustain, while attending LifeStriders premises.

Participant's Name (please print):_____

Participants Signature:_____ Date:_____

Parent/Guardian's Signature:_____ Date:_____

Must be signed parent/guardian if volunteer is under the age of 18

PHOTO RELEASE

I ☐ DO
☐ DO NOT
consent to and authorize the use and reproduction by LifeStriders of any and all photographs and any other audio/visual materials taken of me for promotional material, educational activities, exhibitions or for any other use for in benefit of tie program.

Consent Signature: _____ Date: _____
Client, Parent or Legal Guardian

PATH INTERNATIONAL
Professional Association of Therapeutic Horsemanship International

LifeStriders
Therapeutic Riding Center

S11 W29667 Summit
Avenue (US HWY 18)
Waukesha, WI 53188

Phone: (262) 565-6124
Email: striders@lifestriders.org
www.lifestriders.org
Fax: 866.404.3105

SAFETY RULES

LifeStriders strives to provide a safe riding experience for all of our participants and requires that all participants, families and volunteers abide by our safety regulations. Please review and sign our safety rules.

- Please reserve parking in front of the building for Riders and Participants. Volunteer and Staff parking is available along the side and rear of the building.
- To avoid traffic jams in the driveways please arrive earlier than your designated class time.
- Parents/caregivers must keep siblings, friends and relatives of the rider in the Viewing Areas.
- Please do not bring pets.
- When a volunteer escorts a rider to the parents/caregiver, upon class completion, the parents/caregivers need to contain the rider to the Viewing Areas
- Parents/caregivers will be solely responsible for their rider before and after arena/therapeutic riding time is completed
- Parents/caregivers please walk to the gate to meet your rider after they have dismounted the horse. Once riders are done with arena/therapeutic riding time, parents/caregivers are asked to please help their rider with feeding treats to the horses.
- Parents/caregivers need to remain on LifeStriders premises during therapeutic riding and/or Social skills group sessions.
- For training and safety purposes, we ask that volunteers and participants NEVER HAND FEED THE HORSES.
- Hitting or kicking of horses is NEVER allowed, and will result in dismissal from the program.
- NO guns, knives, weapons or violence of any kind are allowed on LifeStriders premises. This is a zero tolerance rule. Violators will be asked to leave and not allowed to return.
- Please do not climb or lean on any fences, gates or doors.
- No one is to enter the Barn Manager's apartment or other buildings on the property, other than the barn.
- In order to ensure the safest riding conditions, we ask that children and visitors refrain from screaming, running, or ball playing on the premises.
- Only the rider and staff/volunteers are allowed in the teaching arena, unless parent or health care professional presence is requested by instructor.
- Unless instructed to do so by the Therapeutic Riding Instructor, please refrain from giving the riders instructions.

Attire

- A helmet must be worn at all times during the riding lesson hour.
- Riders MUST wear long pants to ride, jeans are preferred.
- All Riders must wear shoes. <u>No one will be allowed to ride or be around the horses if they are bare foot or in sandals.</u> We prefer the shoes have a ¼" heel rather than tennis-type shoes. Volunteers must wear sturdy non-opened toed shoes. We do not recommend steel-toed shoes.
- Volunteers- Please refrain from wearing clothes that is too tight or revealing- No tank tops, bra tops etc.

I have read and understand LifeStriders Safety Policy

Participant Signature: _____ Date_____

Parent/Guardian Signature: _____ Date_____

PATH INTERNATIONAL
Professional Association of Therapeutic Horsemanship International

LifeStriders
Therapeutic Riding Center

S11 W29667 Summit
Avenue (US HWY 18)
Waukesha, WI 53188

Phone: (262) 565-6124
Email: striders@lifestriders.org
www.lifestriders.org
Fax: 866.404.3105

LifeStriders
Progress Reporting

At LifeStriders we strive to provide services that enhance the lives of individuals in a variety of ways. Please answer the following questions to help us design a program that fits the needs of our clients. Thank you.

1. What lead you to seek Social Skills/Counseling services?
   _____

   _____

2. The concerns you wanted to address, for the most part, were: (please check one)
   a. Psychological (assertiveness training, building self esteem, anxiety, depression, anger, etc.)
   b. Behavioral (ADHD related symptoms, oppositional, defiant, etc.)
   c. Physical (Symptoms related to Cerebral Palsy, Down Syndrome, Neurological Disorders, Paralysis, or other medically diagnosed conditions)
   d. Speech and Language
   e. Other _____

3. When you first came to LifeStriders, how serious were your concerns?

   1 2 3 4 5 6 7 8 9 10
   Not Serious Moderately Serious Very Serious

4. Occurrence of concern(s) before starting Social Skills/Counseling services:
   ☐ At least once a day ☐ 2-3 times a week ☐ Once a week ☐ Once every 2 weeks ☐ Once a month

5. Frequency of overcoming concern(s) before starting Social Skills/Counseling services:
   ☐ At least once a day ☐ 2-3 times a week ☐ Once a week ☐ Once every 2 weeks ☐ Once a month

Additional comments:_____

_____

_____

_____

_____

PATH INTERNATIONAL
Professional Association of Therapeutic Horsemanship International

LifeStriders
Therapeutic Riding Center

S11 W29667 Summit
Avenue (US HWY 18)
Waukesha, WI 53188

Phone: (262) 565-6124
Email: striders@lifestriders.org
www.lifestriders.org
Fax: 866.404.3105

DISMISSAL OF VOLUNTEERS AND GUESTS FROM CENTER ACTIVITIES

LifeStriders relies greatly on volunteers as important members of the team who provide services to and assist our clients. We also recognize the extreme importance of the safety and well-being of our clients, volunteers, staff, guests and animals. All Volunteers and guests (guests = participants, siblings, parents, other relatives, friends) are expected to follow LifeStriders rules and policies and may not engage in disruptive, unsafe or inappropriate behavior. In the event a volunteer or guest does not comply, **the following actions may be taken:**

Level 1 **Verbal Warning**
Breaking of LifeStriders rules and /or policies and procedures may be followed by a verbal warning from LifeStriders Staff to be documented in the incident report book.

Level 2 **Written Warning**
Breaking of LifeStriders rules and/or policies and procedures for a second time will be followed by a Personnel/Staff meeting for discussion regarding the infraction. The purpose of the meeting is to determine the exact reason the infraction occurred for second time and discuss with the volunteer/guest how to avoid the circumstance ever occurring again. This meeting will be documented and placed in the incident report book.

Level 3 **Dismissal from Organization**
Immediate dismissal from the property and organization will occur for:

- Endangering the safety of others
- Inappropriate use of the facilities, mailing lists or monies
- Disruptive or abusive behavior to the animals or individuals at LifeStriders
- Repeated disregard of the organizations rules, policies and procedures
- Possession of a weapon, illegal drugs or a paraphernalia
- Being under the influence of alcohol or drugs

DISMISSAL OF VOLUNTEERS AND GUESTS FROM CENTER ACTIVITIES

I have read and understand the policies and program rules by which LifeStriders operates. By signing below, I indicate my willingness to abide by these rules and policies. I further understand that failure to comply with these policies and rules will result in discharge from the program.

Volunteer Name (please print):_____ Date_____

Volunteer Signature:_____ Date_____

Parent/Guardian (please print) _____ Date_____

Parent/Guardian Signature_____ Date_____

PATH INTERNATIONAL
Professional Association of Therapeutic Horsemanship International

LifeStriders
Therapeutic Riding Center

S11 W29667 Summit
Avenue (US HWY 18)
Waukesha, WI 53188

Phone: (262) 565-6124
Email: striders@lifestriders.org
www.lifestriders.org
Fax: 866.404.3105

LifeStriders Payment Policy

LifeStriders is now accepting Major Credit Cards.
PAYMENT POLICY: LifeStriders is a non-profit organization that is committed to offering accessible therapeutic services to our community. We raise funds to offset the cost for parents or participants paying out of pocket and who are not receiving any form of assistance through county agencies, grants, funds etc. One of the ways we are able to keep our prices significantly below going rates is by minimizing accounting costs. LifeStriders charges $30.00/per therapeutic hour if paid for an entire session in advance, or $65.00/per therapeutic hour if paid one (1) week past the session start date, if the participant receives any source of outside funding, or if the participant chooses to stop after starting the session. We ask that the entire session be paid in advance to reserve a spot.
** Billing County Agencies - If you or your child has a case with Milwaukee County and billing has been paid through them in the past, we will continue to bill accordingly unless you tell LifeStriders otherwise. Parents/guardians must email/contact us of any changes in billing agencies, case managers or responsible parties in advance. If payment is not received, the parent(s)/guardian(s) are responsible for any outstanding fees.
** Billing Insurance - LifeStriders will collect payment for all participants at the out of pocket rates to reserve the participants spot and pay for sessions cost up front. LifeStriders will bill your insurance agency at $200 per therapeutic hour. If and/or when insurance remits payment to LifeStriders for dates of service, LifeStriders will reimburse any out of pocket payments for previously paid dates of service. Deductible, co-pay's and co-insurance payments are the responsibility of the named insured card holder/parent(s)/guardian(s), and previous out of pocket payments will be credited towards patient responsibility balances. If billing has been paid through insurance in the past, LifeStriders will continue to bill the same plan unless you tell LifeStriders otherwise. Parent(s)/guardian(s) must email/contact us of any changes in insurance plans, or responsible parties in advance. If payment is not received from insurance, the parent(s)/guardian(s) are responsible for any outstanding fees at the out of pocket rates.

I have read and understand the payment policies by which LifeStriders operates. By signing below, I indicate my willingness to abide by these rules and policies.

Participants Name: _____ Date_____

Participants Signature: _____ Date _____

Parent or Guardian Name: _____ Date _____

Parent or Guardian Signature: _____ Date _____

PATH INTERNATIONAL
Professional Association of Therapeutic Horsemanship International

LifeStriders
Therapeutic Riding Center

S11 W29667 Summit
Avenue (US HWY 18)
Waukesha, WI 53188

Phone: (262) 565-6124
Email: striders@lifestriders.org
www.lifestriders.org
Fax: 866.404.3105

Participant's Consent for Release of Information

I hereby authorize: _____

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

The information is to be released to: Veronica Sosa/Chrystal Schipper/Amber Osterberger/Rosemary Delgado/Melissa Marshall/LifeStriders Therapists/ Intelirev

_____

For the purpose of developing a therapeutic riding/equine activity program for the above named participant. The information to be released is marked below.

- ☐ Medical History'
- ☐ Physical Therapy evaluation, assessment and program plan
- ☐ Occupational Therapy evaluation, assessment and program plan
- ☐ Speech therapy evaluation, assessment and program plan (I.E.P.)
- ☐ Classroom Individual Education Plan
- ☐ Psychosocial evaluation, assessment and program plan
- ☐ Cognitive-Behavioral Management plan
- ☐ Other _____

Consent Signature: _____ Date: _____

Please send materials to: - -

LifeStriders Therapeutic Riding Center
S11 W29667 Summit Avenue (US HWY 18)
Waukesha, WI 53188

PATH INTERNATIONAL
Professional Association of Therapeutic Horsemanship International

LifeStriders
Therapeutic Riding Center

S11 W29667 Summit
Avenue (US HWY 18)
Waukesha, WI 53188

Phone: (262) 565-6124
Email: striders@lifestriders.org
www.lifestriders.org
Fax: 866.404.3105

Physician's Order for Occupational Therapy/Individual Counseling/Group Therapy
(Must Be Signed by Pediatrician or Treating Medical Specialist)

Participant:_____ **has been deemed eligible for:**

_____Occupational therapy services based on evaluation

_____Individual Counseling and/or Group Therapy services based on evaluation

Participants Name: _____ Birthdate: _____

Parent/Guardian _____

Address: _____ Phone: _____

Physician: Please complete the items below. The form may be returned to your client, or to LifeStriders via fax or email. If clinics own prescription form is required, please be sure to include it in the returned packet. Thank you!

_____ Please provide Occupational Therapy services as needed
_____Please provide Individual Counseling/Group Therapy services as needed

Medical Diagnosis/Description of Disability:_____
_____

Precautions/Contraindications:_____
_____

Additional Comments:_____
_____

This referral form will be valid for **1 year**, unless services are terminated, there is a change in the above mentioned participants medical status, or an updated order is necessary.

Physician's Name: _____

Phone: _____

Address: _____

Physician's Signature: _____ Date: _____