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 Application

☐ Therapeutic Riding ☐ Occupational Therapy/Hippotherapy ☐ Physical Therapy/Hippotherapy

Participant: _____ ☐ M ☐ F

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

Ethnicity (for grant writing purposes only): _____

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

Phone: _____ Alternative #: _____ Email _____

Employer/School: _____

Address: _____

Phone: _____

Parent/Legal Guardian: _____

Address (if different from above) _____

Phone: _____

Referral Source: _____

Contact Numbers: _____

How did you hear about the program? _____

Diagnosis(s):

_____

HEALTH HISTORY

Please indicate current or past problems in the following areas:

	Y	N	Comments
Vision			
Hearing			Date/Results of last hearing screen:
Sensation			
Communication			
Heart			
Breathing			
Digestion			
Elimination			
Circulation			
Emotional			
Behavioral			
Pain			
Bone/Joint			
Muscular			
Thinking/Cognition			
Allergies			
Eating/Food Aversions			

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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's DOB: _____
Allergies to medications: _____
Current Medications
(including over the counter) : _____

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, Foster parent or Legal Guardian

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Describe your abilities/difficulties in the following area (include assistance required or equipment needed):

FUNCTION (i.e. Mobility skills such as transfers, walking, wheelchair use, driving/bus riding, and communication skills such as requests for needs/wants, answering/asking questions, etc.)

SOCIAL (i.e. Work/school participation and grade completed, leisure interests, relationships-family structure, support systems, companion animals, fears/concerns, greetings, verbal/non-verbal interactions with peers, etc.)

GOALS (i.e. Why are you applying for participation? What would you like to accomplish?)

TIPS (phrases, gestures, prompts, insights, anything that might help our volunteers / instructors)

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					
Ability to Concentrate					
Eating Habits					
Sleeping Habits					
Ability to form lasting relationships					
Ability to Control Anger					
Other:					

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PARTICIPATION WAIVER AND GUEST LIABILITY RELEASE AGREEMENT

As a participant/rider at LifeStriders, I acknowledge the risks and potential risks of horseback-riding and 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, Subcontracted Instructors, Therapists, Subcontracted Therapists, Aids, Volunteers, and/or Employees for any and all injuries sustained while participating in the LifeStriders 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, Subcontracted Instructors, Therapists, Subcontracted 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/Foster 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 the program.

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

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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 in the back two thirds of the front lot 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 participant 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 the participants before and after arena/therapeutic riding time is completed
- Parents/caregivers please walk to the gate to meet your participant after they have dismounted the horse. Once participants 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 participant and staff/volunteers are allowed in the teaching arena, unless parent or health care professional presence is requested by instructor.
- Please keep the guidance given to riders in alignment with the therapeutic riding instructor's directions.

Attire

- A helmet must be worn by participants at all times during the lesson hour.
- Participants MUST wear long pants to ride, jeans are preferred.
- All participants must wear shoes. No one will be allowed to ride or be around the horses if they are bare foot or in sandals. 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

Volunteer Signature: _____ Date_____

Participant Signature: _____ Date_____

Parent/Foster Parent/Guardian Signature: _____ Date_____

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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 therapeutic riding services?

   _____

   _____

2. The concerns you want to address, for the most part, are: (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. How serious are 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 therapeutic riding:
   ☐ 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 therapeutic riding:
   ☐ At least once a day ☐ 2-3 times a week ☐ Once a week ☐ Once every 2 weeks ☐ Once a month

Additional comments:_____

_____

_____

_____

_____

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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/Foster Parent/Guardian (please print) _____ Date_____

Parent/Foster Parent/Guardian Signature_____ Date_____

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LifeStriders Make-up and Payment Policy

LifeStriders offers, but does not guarantee, one make-up ride per session for missed classes based on availability. LifeStriders offers two (2) opportunities for make-up dates. If dates are not used or if session has concluded, the credit will expire.

LifeStriders accepts check, money order, or major credit cards as form of payment.

PAYMENT POLICY FOR SOCIAL SKILLS AND THERAPEUTIC RIDING:

LifeStriders is a non-profit organization committed to offering accessible therapeutic services to our community. We raise funds to offset the cost for parents or participants paying out of pocket. LifeStriders works to keep costs for families significantly below going rates by minimizing accounting costs. LifeStriders charges $40.00 per therapeutic hour (45-50 minutes) if paid in advance or $85.00 per therapeutic hour if: paid one (1) week past the session start date, the participant receives any source of outside funding, or the participant chooses to pay per date of service. To secure the $40 per therapeutic hour rate, we require that the entire session enrollment fee be paid in advance to reserve a spot.

** Billing County Agencies- If you, your child, or foster child has a case with any county agency and billing has been paid through them in the past, we will continue to bill them unless told otherwise. Parents/foster parents/guardians must email us of any changes in billing agencies, case managers, or responsible parties in advance. Parents/foster parents/guardians are responsible for any outstanding fees not paid by agency.

** BILLING OCCUPATIONAL AND PHYSICAL THERAPY - LifeStriders will bill patient's insurance or county agency at the rate of $400.00 per therapeutic hour (45-50 minutes). Deductible, co-pays, and co-insurance payments are the responsibility of the named insured card holder/parent/guardian. If billing has been paid through insurance in the past, LifeStriders will continue to bill insurance unless told otherwise.

Participant/Parent/Guardian will email/contact LifeStriders of any changes in insurance plans or responsible parties in advance. If payment is not received for any dates of service, participant/parent/guardian assumes responsibility for any outstanding fees at the out of pocket rate of $100.00 per therapeutic hour.

**SUMMER OCCUPATIONAL THERAPY PROGRAM requires a deposit of $500 to reserve a spot for the eight (8) week program. If participant chooses to vacate their reserved time slot after June 1 or does not attend a minimum of 6 out of 8 weeks, the $500.00 deposit will be retained by LifeStriders to pay for the time slot reserved unless arrangements have been approved in writing by LifeStriders' management.

If patient's insurance does not cover services, patient/parent/guardian will be responsible to pay the out of pocket rate of $100.00 per therapeutic hour. The $500.00 deposit will be applied to patient's bill.

**CANCELLATION POLICY FOR OCCUPATIONAL AND PHYSICAL THERAPY SERVICES

Twenty-four (24) hour advance notice is required for cancellation of appointments. Participant/Parent/Guardian will be charged according to the scheduled fee of $65.00 if the cancellation is made with less than 24-hours of notice.

**ATTENDANCE POLICY FOR OCCUPATIONAL AND PHYSICAL THERAPY SERVICES

To maintain your enrollment in LifeStriders' programs, a minimum attendance is required of 5 weeks out of a 7 week session or 6 weeks out of a 8 week session, unless prior arrangements have been approved in writing by LifeStriders' management.

I have read and understand the make-up and 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, Foster Parent or Guardian Name: _____ Date _____

Parent, Foster Parent or Guardian Signature: _____ Date _____

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Participant's Consent for Release of Information

I hereby authorize: _____

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

The information is to be released to: LifeStriders Staff / Therapist's / HCDS

_____

For the purpose of developing a therapeutic 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 _____

In addition, I understand that information may be overheard within the therapeutic setting by others within the vicinity of treatment/on the premises. Minimal information is released to volunteers and used only for the sole purpose of providing effective therapeutic treatment during sessions or during time with the therapist and/or instructor.

Consent Signature: _____ Date: _____

Please send materials to: - -

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Participant's Medical History & Physician's Statement
(Must Be Signed by Pediatrician or Treating Medical Specialist)

Participant: _____ DOB: _____ Height: _____ Weight: _____

Address: _____

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/Needs: _____

Mobility: Independent Ambulation ☐ Y ☐ N Assisted Ambulation ☐ Y ☐ N Wheelchair ☐ Y ☐ N

Braces/Assistive Devices: _____

For those with Down Syndrome: AtlantoDens Interval X-rays, date: _____ Result + -

Neurologic Symptoms of AtlantoAxial Instability: _____

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			

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Physician's Order for Occupational Therapy/Physical 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

_____ Physical 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 Physical 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: _____

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Physician's Statement

(Must Be Signed by Physician or Treating Medical Specialist)

To my knowledge, there is no reason why this person cannot participate in supervised equestrian activities. However, I understand that LifeStriders will weigh the medical information above against the existing precautions and contraindications. I concur with a review of this person's abilities/limitations by a licensed/credentialed health professional (e.g. PT, OT, Speech, Psychologist, etc.) in the implementation of an effective equestrian program.

Name of Participant: _____

Name/Title: _____ ☐ MD ☐ DO ☐ NP ☐ PA ☐ Other: _____
Signature: _____ Date: _____
Address: _____
Phone: ( ) _____ License/UPIN Number: _____
Email: _____