



LifeStriders

NATURE BASED · INTEGRATIVE · THERAPIES

111 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:

DOB: _____ Age: _____ Height: _____ Weight: _____ Veteran: Y N M F
200 lbs or less

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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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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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 "lifesaving" 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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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 buildings for 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.
- No participants are to enter the barn aisle unless accompanied by staff.
- 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 session, parents/caregivers are asked to please assist 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.
- To ensure our staff and volunteers can effectively execute emergency procedures, there is a weight limit of 200lbs or less for all mounted activities, depending on the horse's conformation. Please note that this limit may decrease based on the specific clinical needs and safety requirements of the individual.
- 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.
- 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.
- No visitors are allowed in LifeStriders' paddocks without prior approval from staff and must be accompanied with an approved volunteer or staff member.
- No visitors or volunteers are allowed in LifeStriders' paddocks outside of operating hours without prior approval from staff.
- 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 the instructor.
- Please keep the guidance given to riders in alignment with the therapeutic riding instructor's directions.

Attire

- A helmet and gait belt must be worn by participants at all times during the lesson hour.
- Long pants are recommended for both riders and volunteers.
- All participants / volunteers must wear sturdy closed toe shoes that will not slip off of the foot.
- Volunteers- Please refrain from wearing clothing 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/ /Guardian Signature: _____ Date _____



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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 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

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 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 offers, but does not guarantee, one make-up per session for missed classes, based on availability. Scheduling opportunities are limited to two (2) attempts. If dates are not used or if a 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 charges \$65.00 per therapeutic hour (45-50 minutes) if paid in advance for the entire session (6-9 weeks) or \$120.00 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 \$65.00 per therapeutic hour rate, we require that the entire session enrollment fee be paid in advance to reserve a spot.

Payment Policy for I:1 Equine Therapy- LifeStriders charges \$150.00 per therapeutic hour (45-50 minutes) if paid in advance for the entire session (6-9 weeks) or \$210.00 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 \$150.00 per therapeutic hour rate, we require that the entire session enrollment fee be paid in advance to reserve a spot. **Semi-Private Equine Therapy** - LifeStriders charges \$100 per therapeutic hour if the entire session is paid for in advance, or \$175 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.

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, Speech, 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 discounted rate of \$150.00 per therapeutic hour

Summer 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 discounted rate of \$150.00 per therapeutic hour. The \$500.00 deposit will be applied to patient's bill.

Cancellation Policy for Individuals Paying Per Date of Service 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: To maintain your enrollment in LifeStriders' programs, a minimum attendance of 85% is required (6 out of 7 weeks, 7 out of 8 weeks), 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

1. Participant Information

Full Name: _____ Date of Birth: _____

2. Authorization to Share Records

I hereby authorize LifeStriders to release to AND receive information from:

Organization/Name: _____

Contact Info (Email/Phone): _____

3. Information to be Released Check all that apply:

Physical Therapy evaluation, assessment, and program plan

Occupational Therapy evaluation, assessment, and plan

SLP (Speech) evaluation, assessment, and plan

Counseling / Mental Health Records

Social Skills or Cognitive Behavioral Management Plan

Billing and Payment Records

Other: _____

4. Purpose & Expiration

Purpose of Disclosure: _____

Expiration Date: This authorization will expire one year from the date of signature unless otherwise specified here: _____

5. Acknowledgments & Rights

• I understand that I may revoke this authorization at any time in writing, except to the extent that action has already been taken.

• I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal privacy regulations.

• I understand that my treatment, payment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

Signature of Client or Legal Guardian

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 participant's medical status, or an updated order is necessary.

Physician's Name: _____

Phone: _____

Address: _____

Physician's Signature: _____ **Date:** _____



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Medical Professional's Statement & Evaluation

(Must Be Signed by Pediatrician or Treating Medical Specialist)

Participant Name: _____

DOB: ____ / ____ / ____

Section I: Clinical Assessment of Movement Risks

The participant listed above wishes to engage in equine-assisted activities. These activities involve a horse's rhythmic, three-dimensional movement which mimics the human gait but can place significant stress on the spine, internal organs, and cardiovascular system.

Please check any conditions that apply to this patient:

Category	Potential Contraindications / Precautions
Orthopedic	<input type="checkbox"/> Atlantoaxial Instability (Required for Down Syndrome) <input type="checkbox"/> Spinal Fusion or Internal Hardware (within last 12 months) <input type="checkbox"/> Scoliosis > 30° or Kyphosis <input type="checkbox"/> Osteoporosis / Pathologic Fractures <input type="checkbox"/> Hip Subluxation / Dislocation / Coxa Arthrosis
Neurological	<input type="checkbox"/> Seizures or lack of consciousness (Date of last episode: _____) <input type="checkbox"/> Hydrocephalus / Shunt <input type="checkbox"/> Chiari II Malformation / Tethered Cord <input type="checkbox"/> Spina Bifida / Spinal Cord Injury (Level: _____)
Medical	<input type="checkbox"/> Indwelling Catheter <input type="checkbox"/> Hemophilia or easy bruising <input type="checkbox"/> Skin Breakdown / Decubitus Ulcers <input type="checkbox"/> Uncontrolled Hypertension or Heart Condition
Behavioral	<input type="checkbox"/> History of violence or self-harm

Section: Physician's Attestation

To my knowledge, there is no medical reason why this person cannot participate in supervised equestrian activities. However, I understand that LifeStriders will weigh the medical information above against existing industry 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.) and LifeStriders staff in the implementation of an effective and safe equestrian program.

Medical Professional Name/Title: MD DO NP PA Other: _____

Signature: _____ **Date:** _____

License / NPI Number: _____ **State:** _____

Address: _____

Phone: _____