Walk By Faith Therapeutic Riding, Inc.
34211 290th St. SW
Fisher, MN 56723
Phone: (218) 280-3284
www.walkbyfaiththerapeuticriding.com
email paperwork:
walkbyfaiththerapeuticriding@gmail.com

WALK BY FAITH THERAPEUTIC RIDING'S POLICIES

Summer 2019

Private Lessons (8 Lessons- Will be scheduled with rider and instructor)

Session Costs for Therapeutic Riding

Summer Session I = $320
Private Lessons = $480

- Group Lessons : **$160.00 Rider Registration Paperwork & Deposit Due by April 30th,2017**
  $160.00 (Balance) Due by June 5th, 2017
  Private Lessons: **$240.00 Rider Registration paperwork & deposit due 2 weeks prior to lessons start date.**
  $240.00 (Balance) Due by Date of 1st Lesson

Payment Policy – balance on accounts may be made in full or in 2 installments as listed above.

- Payments should be received by the due date.
- Special Billing – Please call to let us know what is needed.

Attire Policy

Helmets and boots or tennis shoes are required for all riders.

Absence Policy

Please give 24 hour notice whenever possible, this allows us time to inform staff & volunteers. If the rider is absent, Walk By Faith will not make-up that lesson.

Cancellation Policy

If Walk by Faith cancels lessons, we will do our best to schedule a make-up. There may be instances where we are unable to schedule a make-up due to programming.

Walk By Faith reserves the right to deny participation in any program activity that, in the professional opinion of the Walk By Faith staff, presents a risk to the safety and/or well-being of the horses, staff, volunteers and/or other participants.

I have read and understand the above policies.

Signature _____ Date _____

Please return to Walk by Faith

Participant Initials_____

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2019 Participant's Application and Health History (Page 1 of 2)

Participant: _____ DOB: _____ Age: _____

Height: _____ Weight: _____ Gender: M F T-shirt size _____

Home Address: _____ City: _____State: ____ Zip:_____ Home Phone:

_____Parent work phone: _____ Parents/Legal Guardian (BOTH

NAMES if applicable):_____ Address (if different):

_____

Cell Phone:_____Email: _____

Referral Source: _____ Phone: _____

If invoice is to be billed to another source and not the parent/Guardian, please list name and full address below:

_____

HEALTH HISTORY

Diagnosis: _____ Date of Onset: _____

Please indicate current or past special needs in the following areas:

	Yes	No	Comments
Vision			
Hearing			
Sensation			
Communication			
Heart			
Breathing			
Digestion			
Elimination			
Circulation			
Emotional/Mental Health			
Behavioral			
Pain			
Bone/Joint			
Muscular			
Thinking/Cognitive			
Allergies			

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2019 Participant's Application and Health History Cont.' (Page 2 of 2)

MEDICATIONS (include prescription, over the counter; name, dose and frequency)

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

PHYSICAL FUNCTION (i.e. Mobility skills such as transfers, walking, wheelchair use, driving/bus riding)

PSYCHO/SOCIAL FUNCTION (i.e. Work/school including grade completed, leisure interests, relationships – family structure, support systems, companion animals, fears/concerns, etc)

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

Signature: _____ Date: _____

PHOTO RELEASE:

___DO ___DO NOT consent to and authorize the use and reproduction by Walk by Faith 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 the benefit of the program (this includes the website and social media).

Signature: _____ Date: _____

Client, Parent or Legal Guardian

Participant Initials_____

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2019 Authorization for Emergency Medical Treatment Form

Participant:_____DOB:_____Phone:_____

Address:_____City:_____State:____Zip_____

Physician's Name: _____ Preferred Medical Facility: _____

Health Insurance Company: _____ Policy #: _____

Secondary Insurance Company (if Applicable):_____ Policy #: _____

Allergies :_____

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 Walk by Faith 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.

****PLEASE CHOOSE ONE****

□ Consent Plan

This authorization includes x-rays, 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.

□ Nonconsent Plan

I do not give my consent for emergency medical treatment/aid in the case of illness or injury during the process of receiving services or while being on the property of the agency.

In the event emergency treatment/aid is required, I wish the following procedures to take place:

Date: _____ Signature: _____

Client, Parent or Legal Guardian

Participant Initials_____

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2019 Release and Agreement

1 I, _____, the undersigned or my minor child, (herein called Releasor), in consideration of being permitted to use the facilities and services of Walk By Faith Therapeutic Riding Inc. for himself/herself, spouse, my minor child, legal representatives, heirs and assigns, HEREBY RELEASES, WAIVES AND DISCHARGES WALK BY FAITH THERAPEUTIC RIDING INC., (HEREIN CALLED RELEASEE) THE OWNERS AND LESSEES OF WALK BY FAITH THERAPEUTIC RIDING INC. INCLUDING TRAVIS SCHWARZ AND KRISTEN SCHWARZ, THEIR AGENTS, EMPLOYEES AND VOLUNTEERS, FROM ALL LIABILITY TO THE RELEASOR, THEIR SPOUSE, LEGAL REPRESENTATIVES,HEIRS AND ASSIGNS, FOR ANY AND ALL LOSS OR DAMAGE, AND ANY CLAIM OR DAMAGES RESULTING THERE FROM ON ACCOUNT OF INJURY TO RELEASOR'S PERSON, EVEN INJURY RESULTING IN DEATH OF THE RELEASOR, WHETHER CAUSED BY THE NEGLIGENCE OF RELEASOR OR OTHERWISE WHILE THE RELEASOR IS RIDING, WORKING, OR FOR ANY PURPOSE USING THE FACILITIES, EQUIPMENT OR SERVICES OF WALK BY FAITH THERAPEUTIC RIDING INC.

2 I agree to indemnify Walk By Faith Therapeutic Riding Inc., Travis Schwarz, Kristen Schwarz and each of them from any loss, damage or cost they may incur due to the participation or use of the facilities, equipment and services of Releasee due to the presence of myself or my minor child in or upon the property owned, located at or controlled by Walk By Faith Therapeutic Riding Inc. whether caused by the negligence of the Releasees or otherwise.

3 I fully understand any involvement with horses involves some risk of harm or injury to myself, my minor child, my horses or my other property and that risk of damage or injury is a normal incident of involvement with horse related activities and I hereby agree that risk is borne by me and/or my minor child and not by Walk By Faith Therapeutic Riding Inc., Travis Schwarz and Kristen Schwarz, or their officers, members, agents, employees or volunteers.

THIS RELEASE CONTAINS THE ENTIRE AGREEMENT BETWEEN THE PARTIES HERETO AND THE TERMS OF THIS RELEASE ARE CONTRACTUAL AND NOT A MERE RECITAL.

I HAVE CAREFULLY READ THE FOREGOING RELEASE AND KNOW THE CONTENTS THEREOF AND SIGNED THIS RELEASE AS MY OWN FREE ACT.

Releasor (Parent/Guardian) _____

Minor Child _____ Date_____

Participant Initials_____

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SEND TO PHYSICIAN

2019 Participant's Consent for Release of Information

I hereby authorize: _____
(person or facility)

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

The information is to be released to Walk by Faith, for the purpose of developing an Equine Assisted Activity/Therapy program for the above named participant. The information to be released is indicated below:

- Medical History
- Physical Therapy evaluation, assessment and program plan
- Occupational Therapy evaluation, assessment and program plan
- Speech Therapy evaluation, assessment and program plan
- Mental Health diagnosis and treatment plan
- Individual Habilitation Plan (I.H.P.)
- Classroom Individual Education Plan (I.E.P.)
- Psychosocial evaluation, assessment and program plan
- Cognitive Behavioral Management Plan

X Attached Participant's Medical History & Physician's Statement, signed & dated

☐ Other: _____ This

release is valid for one year and can be revoked, in writing, at my request.

Signature: _____ Date: _____ Print Name:

_____ Relation to Participant: _____

Please send materials to:
Walk by Faith
Attn: Kristen Schwarz
34211 290th St SW
Fisher, MN 56723

Participant Initials_____

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SEND TO PHYSICIAN Date: _____

Dear Health Care Provider, Your patient, _____(name)
is interested in participating in supervised Equine Assisted Activities/Therapies.

In order to safely provide this service, our center requests that you complete/update the attached Medical History and Physician's Statement Form. Please note that the following conditions may suggest precautions and contraindications to equine activities. Therefore,

Orthopedic
Atlantoaxial Instability include neurologic symptoms
Coxa Arthrosis
Cranial Deficits
Heterotopic Ossification/Myositis Ossificans
Joint subluxation/dislocation
Osteoporosis
Pathologic Fractures
Spinal Joint Fusion/Fixation
Spinal Joint Instability/Abnormalities

Neurologic
Hydrocephalus/Shunt
Seizures
Spina Bifida/Chiari II malformation/
Tethered Cord/Hydromyelia

Other
Age under 4 years
Indwelling Catheters/Medical Equipment
Medications i.e. photosensitivity
Poor Endurance
Skin Breakdown

Medical/Psychological
Allergies
Animal Abuse
Cardiac Condition
Physical/Sexual/Emotional Abuse
Blood Pressure Control
Dangerous to self or others
Exacerbations of medical conditions (i.e. RA, MS)
Fire Settings
Hemophilia
Medical Instability
Migraines
PVD
Respiratory Compromise
Recent Surgeries
Substance Abuse
Thought Control Disorders
Weight Control Disorder

when completing this form, please note whether these conditions are present, and to what degree.

Thank you very much for your assistance. If you have any questions or concerns regarding this patient's participation in our program, please feel free to contact me at the address/phone indicated above.

Sincerely,

Kristen Schwarz, Center Director
Walk by Faith Therapeutic Riding Inc.

Participant Initials_____

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Send to Physician

2019 Participant's Medical History & Physician's Statement **(Page1)**

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 Xrays Date: _____ Result:_____ Current Neurological Exam:_____Date_____

Positive Neurologic Symptoms of AtlantoAxial Instability: _____

Please indicate current or past special needs in the following systems/areas, including surgeries:

	Yes	No	Comments
Auditory			
Visual			
Tactile Sensation			
Cardiac			
Circulatory			
Integumentary/Skin			
Immunity			
Pulmonary			
Neurolgic			
Muscular			
Balance			
Orthopedic			
Allergies			
Learning Disability			
Cognitive			
Emotional/Psychological			
Pain			
Other			

Participant Initials_____

Send to Physician **(PAGE 2)**

TO My knowledge, there is no reason why this person cannot participate in supervised Equine Assisted Activities/Therapies. However, I understand that the P.A.T.H. Intl. center 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, SLP, Psychologist, etc.) in the implementation of an effective Equine Assisted program.

Name/Title: _____ MD DO NP PA Other _____

Facility Name:_____

Signature: _____ Date: _____

Address: _____

Phone: _____ License/UPIN Number: _____

Participant Initials_____