November 14, 2017

Dear Clients,

Here is your application for participation in therapeutic riding, equine assisted activities, and equine facilitated learning at CHAPS for the 2018 calendar year (Sessions beginning February 27 and ending November 3). Please note the following standards for participation:

- All participants must have a therapeutic goal for riding, and have the recommendation of a physician, therapist, educator, case worker, social worker, etc. to be considered.
- Completed applications must be received by:
    - February 13 for participation in Trimesters 1 – 3 (33 weeks)
    - May 8 for participation in Trimesters 2 and/or 3 (22 weeks)
    - August 14 for participation in Trimester 3 (11 weeks)

The staff at CHAPS is available to help you fill out your application – please call for an appointment to let us help you.

CHAPS Equine Assisted Therapy
Enclosures

Children, Horses and Adults in PartnerShip

Veteran Application

Mailing Address:
PMB 201, 1590 Sugarland Dr. Ste. B
Sheridan, WY 82801
Phone: 307.673.6161 email: info@chapswyo.org

Client Name: _____

Referring agency: _____

Application Received On: ___/___/___ by whom (staff): _____

CHAPS EQUINE ASSISTED THERAPY
PMB 201 1590 Sugarland Dr. Ste. B
Sheridan, WY 82801

Required Information:

Client Name: _____

Prefers to be called: _____ DOB: ___/___/___

Home Address: _____ City: _____, State _____ Zip _____

Client's Email: _____

Client's Employer: _____

Home Phone: _____ Cell: _____

In which branch of the military did you serve? _____

Rank or Grade (optional) _____

Years in military (optional) _____

Specialty (optional) _____

T-Shirt size: _____

CHAPS EQUINE ASSISTED THERAPY
PMB 201 1590 Sugarland Dr. Ste. B
Sheridan, WY 82801

Goals and Objectives

Goals:

Therapeutic Goals (What are you working on in Physical/Occupational/Speech-Language Therapy or in Counseling?):

_____
_____
_____
_____

Leisure interests/hobbies:

_____
_____
_____

Fears/Concerns:

_____
_____
_____
_____

Objectives:

Why are you applying with therapeutic riding and equine assisted activities in 2018?

_____
_____
_____
_____
_____

What goals do you have for participating at CHAPS this year?

_____
_____
_____

Name (print): _____ Date: ___/___/___

Signature: _____

CHAPS EQUINE ASSISTED THERAPY
PMB 201 1590 Sugarland Dr. Ste. B
Sheridan, WY 82801

Contract for Participation

CHAPS agrees to provide the following:

1. One 50- or 90-minute session per week for (check one):
    a. Therapeutic Riding _____
    b. Therapeutic Driving _____
    c. Equine Assisted Learning _____ (ground or mounted)

    (Session length will be determined by instructor based on application & client assessment)
2. A qualified, Professional Association for Therapeutic Horsemanship International (hereinafter referred to as 'PATH') certified instructor with first aid and CPR training, carefully screened and trained equines, and certified volunteers to assist in sessions
3. A safe, appropriate facility built and maintained to ADA standards
4. 1 ASTM – SEI certified helmet for equestrian activity at CHAPS. Participants may leave helmets at CHAPS (recommended) but are responsible for replacing helmets that are taken home and lost or damaged
5. Upon request and with a signed consent for release of information form, CHAPS will share information with other members of the client's support team (progress notes, attend IEP or Plan of Care meetings, etc.)
6. Will provide a list of PATH precautions and contraindications for participation if requested
7. Will provide a copy of this contract and rules/guidelines for participation to each client and/or legal representative
8. If the Therapeutic Riding Instructor has to cancel due to illness, a make-up session will be offered within 30 days
9. A standing weekly session appointment for consistency, assigned on a first come, first served basis

I have read and understand: _____ (Client initials)

Client agrees to provide the following:

1. Prompt transportation to and from the facility or off-site location for sessions and other activities
2. Supervision for clients should they arrive more than 5 minutes before the start of their session or activity
3. Appropriate clothing and footwear (please refer to CHAPS Rules)
4. Proper nourishment, medication, toileting and rest prior to arriving and during time at CHAPS. Clients with bee/insect sting allergies must arrive with a current epi-pen and inform instructor of its whereabouts every time they come to CHAPS
5. Clients who are unable to toilet independently, have a seizure disorder, or cannot be left alone at any time ***must*** have a caregiver with them when they are at CHAPS. If the participant uses the toilet, that caregiver must accompany them to the toilet to assure that it is used properly and left in clean condition
6. Advance notice of no less than three hours prior to sessions if they are unable to attend
7. Updates/notification within one week of changes in medication, therapy or treatments in writing from the client's legal representative for emergency responder information

I have read and understand: _____ (Client initials)

Client further understands that:

1. A no-show occurs when the client does not show up for the scheduled session without 3 hours notice, is excessively late, or is not prepared to participate. No makeup session will be provided and the client forfeits the fees paid.
2. If a client is over 15 minutes late for a private session with or without notice, it may be counted as a no show at the discretion of the Instructor, or the client will have an abbreviated session at the same fee as usually charged for sessions. If the client is too late to participate, the session fee is forfeited by the client/legal representative.
3. If a client is late for a semi-private or group session without notice, and arrives after the session is in progress, the session may be counted as a no show, with session fees forfeited by client/legal representative. Sessions in progress in the arena ***will not*** be interrupted by a latecomer.
4. Client/legal representative agrees to return this application with a check or cash in the amount of the fee for participation (please refer to the sliding scale appearing on the financial aid application).
5. If a client is transported to CHAPS by a school district or agency, and that entity is closed on a day that the client is due to attend a session, it is the responsibility of that client or their support team to find alternative transportation or notify the Instructor if they are not coming. Not doing so will result in a 'no-show' and no make-up session will be provided.
6. More than 2 no-shows will result in probation for those on scholarships. After 3 no shows, a scholarship may be revoked. Notification of probation will be in writing and/or email to the client or legal representative.
7. Clients who miss more than 3 sessions per trimester will be asked to re-consider their commitment to participation.
8. Misrepresenting medical conditions to CHAPS staff may be grounds for termination of participation privileges.
9. Make up sessions are only offered if the Instructor is unable to make it to the session due to illness or other unforeseen occurrences. Make up sessions must be completed within 30 days of the missed session.
10. All sessions will be held regardless of weather conditions and may be moved to a temperature-controlled climate for an un-mounted lesson, with notice.

I have read and understand: _____ (Client initials)

Sessions run 9am thru 5pm, Tuesday through Saturday. Please give us your 1st, 2nd, 3rd time/day preference:

1st: _____ 2nd: _____ 3rd: _____

The undersigned enter into this agreement as stated:

Client Signature: _____

Print name: _____Date: ___/___/___

CHAPS Representative (signature): _____Title: _____

CHAPS Representative (print): _____Date: ____/____/____

Co-Pay Obligation

Each veteran must pay $50 per trimester for services. Payment is due by first lesson of each trimester.

CHAPS EQUINE ASSISTED THERAPY
PMB 201 1590 Sugarland Dr. Ste. B
Sheridan, WY 82801

Agreement of Confidentiality:

As a participant at CHAPS, I agree to hold in strict confidence those names, all medical, social, referral, personnel and financial information regarding clients, staff, volunteers or any and all participants at CHAPS Equine Assisted Therapy at any time and in any capacity. I agree to the above stipulations regarding confidentiality, and furthermore understand that violating this agreement in any way may result in the termination of my association with CHAPS, and possible legal action.

Signature of Client: _____Date:___/___/___

Photo Release:

Please check one and sign:

I Do: _____

I Do NOT: _____

Consent to and authorize the use and reproduction by CHAPS Equine Assisted Therapy of any and all photographs and any other audio-visual materials taken of me/my child/my ward for promotional material, educational activities, and exhibitions or for any other use for the benefit of the program.

Signature of Client: _____Date:___/___/___

Acknowledgement:

I understand that in order to remain a client at CHAPS Equine Assisted Therapy, I will be asked to follow the rules and guidelines of the organization. I have been given a copy of these rules and guidelines and will provide them to any and all persons involved in the transportation or supervision of this client.

I will attend sessions regularly, and if I leave the program for any reason I will relinquish any claim to scholarship funding and return the helmet given to me by CHAPS.

I have read and understand the rules and guidelines, and agree to abide by them.

Signature of Client: _____Date: ___/___/___

Signature of CHAPS Representative: _____ Date: ___/___/___

CHAPS EQUINE ASSISTED THERAPY
PMB 201 1590 Sugarland Dr. Ste. B
Sheridan, WY 82801

Authorization for Emergency Medical Treatment

Participant's Name: _____DOB:___/___/___

Physician's Name: _____ Preferred Medical Facility: _____

Health Insurance Company: _____ Policy #: _____

Allergies to medications: _____

Current medications (including over-the-counter medications): _____

_____

Emergency Contact: _____

Relationship to Client: _____ Phone: _____

Emergency Contact: _____

Relationship to Client: _____ Phone: _____

In the event that emergency medical aid/treatment is required due to injury or illness during the process of receiving services, or while being on the property of CHAPS, I authorize CHAPS Equine Assisted Therapy staff 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 treatment

Please check and complete one of the following plans:

_____**Consent Plan:**

This authorization includes X-ray, surgery, hospitalization, medication and any treatment procedure deemed 'life saving' by the physician. This provision will be invoked only if the person(s) above is unable to be contacted.

Date: ___/___/___

Client Signature: _____

Witness: _____ Date: ____/____/____

OR

_____**Non-Consent 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 CHAPS Equine Assisted Therapy. I agree to have a parent or legal guardian remain on site at all times during equine assisted activities and therapeutic riding sessions. In the event that emergency treatment/aid is required, I wish the following procedure to take place:

_____

_____

Client Signature: _____

Witness: _____ Date: ___/___/___

CHAPS EQUINE ASSISTED THERAPY
PMB 201 1590 Sugarland Dr. Ste. B
Sheridan, WY 82801

CHAPS Equine Assisted Therapy

General Liability Release

The undersigned is aware that all activities involving horses including but not limited to riding, driving, grooming, leading or events involving horses pose many inherent dangers, risks and hazards including but not limited to bodily injury and physical harm to rider, groomer, leader, handler, side walker, photographer, spectator and/or helper. I (the undersigned) freely and fully assume all such risks, dangers, and hazards and the possibility of injury, death, property damage or loss resulting from such risks, dangers and hazards.

I hereby agree as follows (please initial each line):

_____1) To assume and accept all risks, dangers and hazards in connection with my use or my minor child's or ward's use of the facilities at CHAPS or any off site activities sponsored by CHAPS

_____2) To waive any and all claims that I may have against CHAPS and the property owners as a result of my, my minor child or ward's use of the facility or participation in any off site activity sponsored by CHAPS

_____3) To release CHAPS, it's employees, board of director members, volunteers, spectators, clients, property owners and all people involved with CHAPS from any and all liability, rights of action, or causes of action arising out of contract, tort or otherwise for any loss, damage, injury or expense that I, my minor child or ward, next of kin of myself, my minor child or ward, may suffer or incur as a result of use of the facilities or participation in off-site activities sponsored by CHAPS due to any cause whatsoever

_____4) The undersigned agrees to hold harmless and indemnify CHAPS, and any employees, volunteers, board of director members, spectators, clients and or property owners from any and all liability for personal injury, property damage or death suffered by myself, my minor child or ward or by a third party as a result of use of and/or presence at the facility or off site activities sponsored by CHAPS

_____5) That, in the event of my, my minor child or ward's injury or death, this release and indemnity agreement shall be effective and binding upon mine and my minor child or ward's heirs, next of kin, executors, administrators and assigns in relation to CHAPS, it's property owners and any and all people involved.

Adult:

I acknowledge that I have read and understood this release and indemnity. I am at least 18 years of age and am aware that by signing this document, I am affecting legal rights and liabilities of myself, my heirs, next of kin, executors, administrators, and assigns in relation to CHAPS, its property owners and any and all people involved.

Name (print): _____ Date: ___/___/___

Signature: _____

Witness: _____

CHAPS EQUINE ASSISTED THERAPY
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Participant Medical History (to be filled out by Client)

Please check any of the following that apply:

☐ Lack of Concentration	☐ Learning Disabilities	☐ Developmental Delay	☐ Mentally Challenged
☐ Hyperactivity	☐ Self-Injurious Behavior	☐ Tics/stereotypic Behavior	☐ Sensitivity, preferences
☐ Anxiety	☐ Phobias	☐ Aggressive	☐ Assaultive
☐ Sensory issues	☐ Unpredictable/Dangerous	☐ Psychosomatic Symptoms	☐ Manipulative
☐ Sexual Abuse	☐ History of Physical abuse	☐ History of emotional abuse	☐ Other (please explain on back of page)

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

Special Needs:	Yes	No	Describe:
Auditory	☐	☐	
Visual	☐	☐	
Tactile Sensation	☐	☐	
Speech	☐	☐	
Cardiac	☐	☐	
Circulatory	☐	☐	
Integumentary/Skin	☐	☐	
Digestion	☐	☐	
Elimination	☐	☐	
Immunity	☐	☐	
Pulmonary	☐	☐	
Neurologic	☐	☐	
Muscular	☐	☐	
Balance	☐	☐	
Orthopedic	☐	☐	
Allergies	☐	☐	
Learning Disability	☐	☐	
Cognitive	☐	☐	
Emotional/Psychological	☐	☐	
Behavioral	☐	☐	
Pain	☐	☐	
Other	☐	☐	

Describe mobility; i.e. independent ambulation, assisted ambulation, wheelchair, braces, etc.

_____

To the best of my knowledge, the medical history is true and accurate:

Client Signature: _____ Date: ___/___/___

CHAPS EQUINE ASSISTED THERAPY
PMB 201 1590 Sugarland Dr. Ste. B
Sheridan, WY 82801

Participant's Medical History and Physicians Statement

November 14, 2017

Dear Health Care Provider;
Your patient, _____, is interested in participating in supervised equine assisted activities and/or therapeutic riding at CHAPS Equine Assisted Therapy. In order to safely provide this service, we request that you complete/update the attached Medical History and Physician's Statement Forms. Please note that the following conditions may suggest precautions and contraindications to participating. Therefore, when completing these forms, please note whether these conditions are present, and to what degree:

Participant Name: _____ **DOB**: ___/___/___

Height: _____ **Weight**: _____

Diagnosis:

1. _____
   Date of onset: ___/___/___
2. _____

   Date of onset: ___/___/____ (*If more room is needed, please use a separate page)*

Past/prospective surgeries:

1. _____
   Date:___/___/___
2. _____
   Date:___/___/___ (*If more room is needed, please use a separate page)*

Medications: _____

Possible Medication Side Effects: _____

Seizure Type: _____ Controlled? Y ___ N ___ Date of last Seizure: ___/___/___

Shunt: Y ___ N ___ Date of last revision: ___/___/___

Indwelling Catheter/Medical Equipment: Y ___ N ___
Describe: _____

Braces/Assistive Devices: Y ___ N ___
Describe: _____
May they be used while participating in Therapeutic Riding and Equine Assisted Activities? Y ___ N ___

Given the above diagnosis and medical information, this person is not medically precluded from participation in equine assisted activities and therapeutic riding. I understand that CHAPS Equine Assisted Activities is a PATH International Center and will weigh the information given against existing precautions and contraindications as noted by PATH International. Therefore, I refer this person to CHAPS Equine Assisted Therapy for ongoing evaluation to determine eligibility for participation.

Name/Title: _____MD DO NP PA

Other: _____

Signature: _____

Name (print): _____ Date: ___/___/___

Address: _____

Telephone: (____) _____ Fax: (____) _____

License/ UPIN Number: _____

CHAPS EQUINE ASSISTED THERAPY
PMB 201 1590 Sugarland Dr. Ste. B
Sheridan, WY 82801

November 14, 2017

Dear Mental Health Care Professional;

Your patient, _____, is interested in participating in supervised equine assisted activities and/or therapeutic riding at CHAPS Equine Assisted Therapy. In order to safely provide this service, we request that you complete/update the attached Mental Health Data. Please note that the following conditions may suggest precautions and contraindications to participating. Therefore, when completing these forms, please note whether these conditions are present, and to what degree:

Medical/Psychological

☐ Aggressive	☐ Allergies	☐ Animal Abuse	☐ Anxiety
☐ Assaultive	☐ Abuse: Physical, Sexual or Emotional	☐ Dangerous to Self or Others	☐ Delusional
☐ Dissociations	☐ Fire Setting	☐ Hallucinations	☐ History of running away
☐ Parental or Familial Support Issues	☐ Legal/School/ Employment Problems	☐ Manipulative	☐ Migraines
☐ Phobias	☐ Recent Hospitalizations	☐ Social Skill Problems	☐ Substance Abuse
☐ Thought Control Disorders	☐ Unpredictable or Dangerous Behavior	☐ Weight Control Disorders	☐ Medications, i.e. photosensitivity

Thank you in advance for your assistance. If you have any questions or concerns about this patient's participation in equine assisted activities, please contact the center at the address, phone or email above. Your assistance in providing correct, updated medical information about our shared client is ***essential*** to our staff to provide safe, appropriate lesson plans that will avoid exacerbating medical and psychological conditions.

Sincerely,

CHAPS Equine Assisted Therapy

Mental Health Data Form

Client's Name: _____Age:_____ DOB: ___/___/___

Home Phone: _____ Cell Phone: _____

Address: _____

Physician: _____

Therapist: _____Title: _____

Phone: _____

Address: _____

Fax Number: _____ Email: _____

Diagnosis (DSM-IV)

Axis I: _____

Axis II: _____

Axis III: _____

Axis IV: _____

Axis V: _____

Presenting Problems

_____

_____

_____

_____

Current Medications

Drug	**Dose**	**Route**	**Time**	**Diagnosis**

Psychiatric Treatment History

Current History including date and location of current diagnosis:

_____

_____

_____

_____

Outpatient History:

_____

_____

Inpatient Therapy:

_____

_____

Signature: _____

Name, Title (print): _____

Address: _____

Telephone: _____Fax: _____Email: _____

The rest of this page is intentionally left blank

CHAPS EQUINE ASSISTED THERAPY
PMB 201 1590 Sugarland Dr. Ste. B
Sheridan, WY 82801

CHAPS Equine Assisted Therapy Standards and Guidelines – Participants should keep this page

Dress Code:

1. Footwear: Hard soled shoes or boots with a low heel are preferred for therapeutic riding. Sneakers may be used for vaulting, and boots or footwear that will protect feet from cold; heat, water, and injury are needed for other equine assisted activities. Please ask your instructor if you are unsure if your footwear is appropriate.
2. Long pants: no shorts, skorts, culottes, carpi pants or dresses/skirts. Riding breeches, form fitting jeans or tights are acceptable.
3. Socks: tube socks that will stay up under the knee are recommended for comfort and safety.
4. Shirts: should have at least a cap sleeve to protect shoulders, and kept tucked in or be form fitting.
5. Please dress appropriately for winter weather, in form fitting coats that do not hang below the hips or are so loose that they cannot get caught on a saddle horn when dismounting.
6. Jewelry: no jewelry that can get caught in manes or tails ('dangling' earrings, necklaces, rings/bracelets, etc.)
7. Electronic equipment: Cell phones, iPods, Walkman or any other personal electronic devices are not allowed the riding areas. Participants who arrive with electronic devices will be asked to leave them in the car or instructor's office during session. Family members or participant's guests who are watching the session must turn off ringers or sounds for any electronic equipment they have on their person.
8. Helmets are provided by CHAPS and must be worn at all times by clients when in the barn or arena or when mounted on a horse or the Equicizer.

General barn etiquette, procedures and safety rules:

1. All clients must have an annually updated and fully completed application to participate
2. No running, screaming or boisterous behavior on the property. Clients must be able to monitor their own behavior appropriately *or have a caregiver with them for supervision*
3. Participant's pets are not allowed at CHAPS, other than service dogs (if service dogs are present, there must be someone to supervise the dog while the client is working around the horses)
4. There is client and drop off parking in front of the barn for ambulatory and handicap-equipped vehicles. Please do not park in the parking lot in front of the green house or on the side of the green house
5. Please do not hand feed horses or reach through the bars of the stalls to pet them
6. Please supervise children at all times when they are not under the direction of their Instructor. Please do not allow children who are not participating in the session to distract participants with loud or unruly behavior
7. All equipment areas and off-limits areas are labeled or located on one of several maps located around CHAPS. Please do not visit the houses or other off limit areas at the facility
8. No unattended children or dependent adults in the rest room.

9. Clients who cannot sit unattended in the event that transportation picking them up is late or if typical behaviors may lead to them being asked to leave the class *must have a care giver present*
10. Clients are asked to wait in their car until the Instructor comes to the door to invite them in, particularly if there are horses in the aisle or if no one is available to supervise them. They may sit with a caregiver in the Memory Garden while waiting for the Instructor to start the session if the aisle is clear when they arrive
11. Clients are not to open stall doors, handle horses or work with a volunteer unless the Instructor is present
12. Clients are under the direction of their Instructor during the session. Any client that willfully disobeys an instructor's direction may be asked to dismount or stop participating in the activity and wait outside the arena for the session to conclude. If you have suggestions for the Instructor, please wait until after the session – your input is very important to the instruction staff but may be distracting during the session
13. Please feel free to observe a lesson with your child or client – however, please do not distract them by speaking to them or attracting their attention once the session has begun, for safety purposes.
14. CHAPS certified Volunteers are provided for session assistance
15. Clients who arrive with medication to take or use (epi-pen, for example) must let the Instructor know where it is upon arrival
16. Clients or caregivers who arrive at CHAPS under the influence of alcohol or illegal drugs, or who bring weapons to CHAPS will be asked to leave immediately, and their association with CHAPS may be terminated

Make Up Sessions and Weather Conditions

1. Sessions will be held regardless of weather conditions and temperatures. If it is under 30 degrees the session may be moved to a climate controlled meeting area (CHAPS office, or a room or space at an agency)
2. Make up sessions are not available for weather related cancellations by participants
3. Make up sessions will be offered only if the Instructor has to cancel a session due to illness or unforeseen circumstances
4. Participants will have 30 days to schedule and participate in a make-up session if offered