NEW PARTICIPANT APPLICATION

To be updated annually.
For the purposes of grants and other funding, we request that you complete **ALL** information in this packet.

Today's Date: _____ / _____ / _____ (mm/dd/yyyy) How did you hear about Winslow? _____

Participant's Name: _____ DOB: _____ / _____ / _____ Age: _____
(mm/dd/yyyy)

Preferred Name: _____ Gender: M F

Participant's Address: _____ City: _____ State: ___ Zip: _____

Client/Parent/Legal Guardian Print Name: _____

Method(s) of contact: ☐ Home Phone _____ ☐ Cell Phone _____

☐ Email _____

Legal Guardian Name: _____ Relation to Participant: _____

Home Phone: _____ Cell: _____

Address (if different from above): _____

In the event Legal Guardian(s) cannot be reached:

Emergency Contact Name: _____ Phone Number: _____

Emergency Contact Name: _____ Phone Number: _____

Responsible for Billing:

First and Last Name: _____ Signature: _____

Home Phone: _____ Cell: _____ Email: _____

Mailing address: _____

City: _____ State: _____ Zip: _____

Dear Participants of Winslow Therapeutic Riding Center,

Thank you for your interest in becoming a participant with us! Winslow's mission is "Healing with Horses". Winslow is a not-for-profit 501(c)(3) organization and a PATH Intl. Premier Accredited Center. All of our instructors are certified by PATH, Intl. (Professional Association of Therapeutic Horsemanship, International) or under the supervision of PATH, Intl. certified instructors. Winslow has been providing therapeutic riding and equine-assisted activities to the greater tristate area since 1974.

Here at Winslow we strive to provide the safest conditions as well as a state of the art facility. In order to maintain our excellence, we ask that all participants and or their families adhere to our policies. Please review the following policies for Winslow Therapeutic Riding Center below. Failure to commit to these policies will result in loss of riding and or barn time at the participant's cost. Please initial next to each policy as well as sign and date the bottom of this form.

Thank you and welcome to Winslow!

Annual Update Policy:
An annual update of the Participants Application and Medical Forms is required. This includes but is not limited to the Participant's application, full health history, all medications if applicable, all liability and photo releases, authorization for emergency medical treatment as well as Section 1 on the participation income form**. Should a participant need to take a break for medical reasons a physician's release will be required prior to resuming lessons. _____ Initial

Mail and Email Policy:
The client or parent filling out this form will be added to Winslow's mail and email list. You may opt out of either list at any time. Winslow *will not* share this information with any other party. _____ Initial

Helmet Policy:
When near/on horses, participants *must* wear an ASTM-SEI-approved riding helmets. Please note bike helmets and or ski helmets are not acceptable. _____ Initial

Clothing Requirements:
Long pants and closed-toe shoes (with heels if possible) is required. Slip-on and Crocs-like shoes are not permitted during lessons _____ Initial

Inclement Weather Policy:
Classes will only be cancelled in the event of dangerous or threating weather. To determine cancellations, call Winslow directly at 845-986-6686. _____ Initial

Weight Limit:
I understand that there is a weight limit of 225 lbs. for all **mounted** activities and acknowledge if the participant surpasses this weight, they will be able to participate in unmounted activities as they work towards meeting the weight limit. Each equine has a specific weight limit and different capabilities. _____ Initial

Siblings:
If siblings are in attendance with parents and/or caregivers to the client participating in class, parents are responsible for the direct supervision of these children at all times. All individuals in the spectator area must remain calm and quiet. Noises and lots of activity can startle horses and distract students. _____ Initial

Safety:
Winslow reserves the right at any time to refuse any participant we cannot safely accommodate. _____ Initial

Photo and Video Recording Policy:
Winslow's confidentiality policy and photo release policy extend to participants, volunteers, animals, and staff. Prior to taking a photo or video recording your participant, you must ask the instructor to ensure that all individuals present have a photo release. NO flash photography as this could startle the animals. _____ Initial

Cellphone/Electronic Use:
Phone calls are not permitted in the arena. Please mute the volume of all cellphones and electronic devices as to not disturb lessons. Phone calls may be made in the waiting room area. Cellphones or cameras are not permitted to be on your person if you are participating in lessons. _____ Initial

Signing below is acknowledging that you have read and understand all of our policies and procedures here at Winslow Therapeutic Riding Center.

Participant's Name: _____

Date: _____ / _____ / _____ Client/Parent/Legal Guardian Signature: _____
(mm/dd/yyyy)

Confidentiality Agreement:
I agree to respect and observe privacy and confidentiality of the participants, volunteers and personnel of Winslow Therapeutic Riding Center and not to discuss or disclose any sensitive information about any person or their family.

Participant's Name: _____

Date: _____ / _____ / _____ Client/Parent/Legal Guardian Signature: _____
(mm/dd/yyyy)

Photo Release:
I hereby consent to and authorize the use and reproduction by Winslow of any and all photographs and any other material, educational activities, exhibitions or for any other use the benefit of the program.

☐ Consent ☐ Do Not Consent

Participant's Name: _____

Date: _____ / _____ / _____ Client/Parent/Legal Guardian Signature: _____
(mm/dd/yyyy)

Liability Release: _____ (Participant's Name) would like to participate in the Winslow Therapeutic Riding Program. I acknowledge the risks and potential for risks of horseback riding. However, I feel the possible benefits to myself/my child/my ward are greater than the risk assumed. I hereby intend to be legally bound, for myself, my heirs and assigns, executors and administrators, waive and release all claims for damages against Winslow Therapeutic Riding Unlimited, Inc. its Board of Directors, Instructors, Therapists, Aids, Volunteers, and Employees for any and all injuries and losses, I/my child/my ward may sustain while participating in the Winslow Program.

Date: _____ / _____ / _____ Client/Parent/Legal Guardian Name: _____
(mm/dd/yyyy)
Client/Parent/Legal Guardian Signature: _____

Late Participant AND Cancellation Policy:
It is important for the participant to arrive 5 minutes prior to the scheduled riding time. If a client is more than 15 minutes late to a lesson, he/she will do an unmounted lesson for the remainder of the time and the participant will be charged full lesson fee. Lesson cancellations made within 24 hours of the lesson time will incur a $25 charge.

Participant's Name: _____

Date: _____ / _____ / _____ Client/Parent/Legal Guardian Signature: _____
(mm/dd/yyyy)

WINSLOW THERAPEUTIC RIDING CENTER
PARTICIPANT'S APPLICATION AND HEALTH HISTORY

To be updated annually.

Please complete ALL information in the application and health history.

Participant's Name: _____ DOB: _____ / _____ / _____ Age: _____
(mm/dd/yyyy)

Height: _____ (inches. feet) Weight: _____ lbs. Gender: M F Ethnicity: _____

Participant's School: _____

Primary Care Provider's Name: _____Provider's Phone Number: _____

DISABILITY: PRIMARY_____ SECONDARY_____

*****The DISABILITY field must be filled out. If there is no disability, write NONE or application will be considered incomplete*****
Riders with Down syndrome are required to have an annual medical clearance from a licensed physician that includes a neurological exam that specifically denies any symptoms consistent with atlantoaxial instability (AAI)

Please indicate current or past problems in the following areas:

	Y	N	Comments
VISION			
SENSATION			
COMMUNICATION			
HEART			
BREATHING			
DIGESTION			
ELIMINATION			
CIRCULATION			
EMOTIONAL			
BEHAVIORAL			
PAIN			
BONE/JOINT			
MUSCULAR			
THINKING/COGNITIVE			
ALLERGIES			
SEIZURES			
OTHER, please describe			

PLEASE LIST ALL MEDICATIONS TAKEN AND FOR WHAT PURPOSE

MEDICATION	**PURPOSE OF MEDICATION**

Functional Status	**Independent**	**Some Assistance**	**Dependent**
Sitting			
Standing			
Walking			
Wheelchair			
Dressing			
Toileting			
Feeding			

Explanation of Conditions/Diseases Checked:

_____

_____

_____

Language: ☐ Verbal ☐ Sign ☐ Gestural ☐ Augmentative

Current Grade Level _____ Math Grade Level _____ Reading Grade Level _____

Social Development (i.e., work/school, leisure interest, etc.):

_____

_____

_____

What form of behavior modifications do you use, if any?

_____

_____

_____

What goals would you like to accomplish during your time at Winslow?

_____

_____

_____

_____

_____

Have you served in the Military: ☐ YES ☐ NO (go to next page)

If you answered YES, are you: ☐ Currently Serving ☐ A Veteran ☐ On Leave

What branch of the Military are/were you enlisted? _____

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

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 Winslow Therapeutic Riding Unlimited, Inc. 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.

Participant's Name: _____

Primary Care Provider's Name: _____

Primary Care Provider's Facility: _____

Primary Care Provider's Phone Number: _____

Preferred medical facility for treatment: _____

Health Insurance Company: _____ Policy # _____ Group # _____

Consent for Treatment Plan:

☐ Consent ☐ Do Not Consent

This authorization is for _____ (Participant's Name) and 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 below or any other legal guardian is unable to be reached.

Date: _____ / _____ / _____ Client/Parent/Legal Guardian Name: _____
(mm/dd/yyyy)

Client/Parent/Legal Guardian Signature for Consent for Treatment: _____

Program Participation Income Survey

Orange County Community Development Office Requirement:
Winslow Therapeutic Riding Center is required by the Orange County Community Development Office (OCCD) to track the income range of all participants in order to continue receiving funding which subsidizes **ALL** lesson costs. **Using this form, in Section 1 please circle the applicable income limit listed under your household size.** Section II of the form is voluntary**.**

PLEASE NOTE: Winslow is committed to keeping the confidentiality of all client information and submits it anonymously. Please be assured that all data is held in strictest confidence. Thank you for helping Winslow qualify for funding that benefits ALL of our clients.

SECTION I

Town/City: _____ State: _____ Zip: _____ County: _____

# of people in your household enrolled in Winslow's programs: _____ Year of Enrollment: _____

Using the chart below, please CIRCLE your income level based on the number of individuals in your household.
(Example: If your family consists of 2 people and your yearly income is $37,500, you would circle where "**2 persons**" and "**(2) Equal to or less than $54,400**" meet

Number in household	1 person	2 persons	3 persons	4 persons	5 persons	6 persons	7 persons	8 persons
(1) Equal to or less than	$31,300	$35,800	$40,250	$44,700	$48,300	$51,90	$55,450	$59,050
(2) Equal to or less than	$47,600	$54,400	$61,200	$68,000	$73,450	$78,900	$84,350	$89,800
(3) Greater than	$47,600	$54,400	$61,200	$68,000	$73,450	$78,900	$84,350	$89,800

SECTION II

How many families currently reside at the address listed above? _____
If more than one family, please have each family complete this questionnaire. Please copy the questionnaire or request a blank copy from Winslow.

Do you or anyone in the household receive rental income from the property listed above or any other owned? □ Yes □ No

Residency: □ Own □ Rent

Ethnic Group – please indicate the choice that pertains to the participant
□ Hispanic or Latino □ Non-Hispanic or Latino

Racial Group – please indicate the choice that pertains to the participant
□ White
□ Asia
□ Asian & White
□ Multi Racial
□ Black/African American
□ Black/African American & White
□ Native Hawaiian/Other Pacific Islander
□ American Indian/Alaska Native
□ American Indian/Alaska Native & White
□ American Indian/Alaska Native & Black/African American

Do you or anyone in the household receive alimony/child support? □ Yes □ No

# of people in your family over the age of 62 years old: _____

Are any family members disabled? □ Yes □ No If yes, please indicate how many: _____

Participant's Medical Clearance and Physician Statement

(Must be signed by a physician in order to ride)

Patient Name: _____ Patient DOB: _____ / _____ / _____

Height: ___ ft. ___ in. Weight: _____lbs.

Address: _____City: _____State: ____Zip: _____

Primary Diagnosis (write N/A if none): _____ Date of Onset: _____ / _____ / _____

Past/Prospective Surgeries (write N/A if none): _____

Medications (write N/A if none): _____

Seizure disorder? Yes No Type: _____ Controlled? Yes No Date of Last Seizure: ___ / ___ / _____

Does patient have a shunt present? Yes No Date of Last Revision: _____ / _____ / _____ N/A

Special Precautions/Needs: _____

Mobility (please circle one): Independent Ambulation Assisted Ambulation Wheelchair

Please indicate any braces of assistive devices (write N/A if none): _____

For those with Down syndrome: Result of Neurological exam of Atlantoaxial Instability: _____Present _____Absent

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

	Y	N	Details
Auditory			
Visual			
Tactile Sensation			
Speech			
Cardiac			
Circulatory			
Integumentary/Skin			
Immunity			
Pulmonary			
Neurological			
Muscular			
Balance			
Orthopedic			
Allergies			
Learning Disability			
Cognitive			
Emotional/Psychological			
Pain			
Other			

To my knowledge, there is no reason why this person cannot participate in supervised equine activities. However, I understand that the PATH Accredited Center will weigh the medical information above against the existing precautions and contraindications.

Physician Name: _____ MD DO NP PA Other_____

Signature: _____ Date: _____ / _____ / _____

Facility Address: _____

Facility Phone: _____ License/UPIN number: _____