## Thinking Equine Assisted Activities are for you or someone you know?

To be sure that this is a good fit for everyone involved, and to get each client scheduled in a space that best works for them, ECL has a five step intake process.

1. **GIVE US A CALL AT 517-755-2175 or send us an email**
   We'll chat with you about the specifics of the potential student/situation and figure out if there's a fit in our program that would be best.

2. **FILL OUT CLIENT PAPERWORK**
   Client paperwork MUST BE COMPLETED PRIOR TO YOUR ASSESSMENT.
   Participant packets can be requested and returned to email ecl@lansingschools.net

3. **SCHEDULE AN ASSESSMENT**
   Assessments are scheduled and are conducted by our instructors. These appointments help us determine how we can make your experience at ECL most beneficial and are designed to give everyone a good idea of what to expect on their first day at the barn. We introduce you to the facility, the program process; determine which horse is appropriate, and what level of support is needed.

4. **ATTEND YOUR ASSESSMENT**
   Please let us know if you are unable to attend your scheduled assessment with our instructors.

5. **SIGN UP FOR A RIDING SESSION**
   We will work with you to determine the best fit available on our schedule, for your needs and walk you through the sign up process. This often happens prior to leaving your assessment. We will do our best to find something that works!

**We look forward to seeing you at the barn!**

## PARTICIPANT APPLICATION

**Riding Program:** ☐Beekman Student ☐ Community Rider ☐ Therapy ☐Non-Therapy

**GENERAL INFORMATION:**
Participant Name:_____DOB:_____ Age:_____

Address:_____City:_____State: _____
Zip:_____ County:_____

Gender: M ☐ F☐ Height:_____ Weight: _____*175 lb limit

Parent/Legal Guardian:_____

Address (if different from above):_____
Email address:_____

Phone: Primary:_____Other:_____

School/Program:_____

Person/Party responsible for payment:_____

Relationship to Rider:_____

Billing address/Phone# (if different from above):_____

**GOALS**
What would you like to accomplish in our program?_____
_____

Additional information that would be helpful in class selection and lesson planning:
_____

Please list any accommodations/concerns the instructors should be aware of:
_____

Has the participant had any prior experience with horseback riding? Yes☐ No☐

Other comments or information we should know:_____

_____

**Warning: Under the Michigan equine activity liability act, an equine professional is not liable for an injury to or the death of a participant in an equine activity resulting from an inherent risk of the equine activity.**


# LIABILITY RELEASE FORM

I agree to the following agreement with the Equine Center for Learning (ECL) and the Lansing School District, a Michigan non- profit Organization, (hereafter referred to as "Center"), as a condition for allowing me, and the persons identified below, to enter the Center's premises and surrounding land, to be near horses, participate in equine-assisted activities, ride the horses, work near the horses, participate in hay rides, handle horses, use equipment, work with staff and volunteers, and/or receive instruction or guidance in riding, grooming, or handling the horses (these activities will hereafter be referred to in this document as "The Activities").

Participant's Name:_____

Parent/Guardian (if participant is under 18): _____

Home Address: _____Phone:_____

Emergency Contact (In addition to parent/guardian: _____Phone:_____

**IT IS HEREBY AGREED AS FOLLOWS:**

I/we are aware and acknowledge the inherent dangers, hazards and risks, associated with equine activities. I/we understand that the inherent risks of the equine activities mean those dangerous conditions which are an integral part of the equine activities, include but not limited to:

1. The propensity of any equine to behave in ways that may result in injury, harm or even death to persons on or around them and/or damage to property in their vicinity.
2. The unpredictability of an equine's reaction to such things as sounds, sudden movement and unfamiliar objects persons or other animals.
3. The equine's response to certain hazards such as surface and sub-surface objects.
4. Collisions with other equines, animals, people and objects.

The potential of any participant to act in a negligent manner that may contribute to injury to the participant or others, such as falling to maintain control over the equine or to act within his/her ability. I/we assume these risks and accept the consequences involved in the participation of the participant registered on this form. I/we will consult with the instructor of the Equine Center for Learning (ECL) for advice in circumstances where safe practices are in doubt.

**Warning: Under the Michigan equine activity liability act, an equine professional is not liable for an injury to or the death of a participant in an equine activity resulting from an inherent risk of the equine activity.**

I/we have read and fully understand the content of this release of liability and agree to comply with the intent to hold harmless or to indemnity the Equine Center for Learning (ECL), the Lansing School District, its' staff, volunteers or any other individuals and/or organizations involved, from any liability or injury that may result from participation in this program.

I/we understand that the Equine Center for Learning (ECL), always recommends that I/we seek the advice of a physician, as many of The Activities pose special physical risks to the participant and even to the volunteer. I/we acknowledge that it is my/our responsibility to make the Equine Center for Learning (ECL), aware of any conditions that may affect my ability to handle, ride and /or be near an equine.

I/we have received information on the signs, symptoms and consequences of concussions in accordance with Public Acts 342 and 343 of 2012. By signing below, I acknowledge that I have read, fully understand, and agree to be bound by the provision of this release.

**Signature of parent/guardian/participant of legal age** **Date**

## Authorization for Medical Treatment

___I, give my consent, in case of a medical emergency, to authorize the Equine Center for Learning staff to provide such medical assistance as they determine necessary. I authorize any licensed physician and/or medical facility to provide medical, surgical care and/or hospitalization for the participant, including anesthetic, which medical professionals determine to be necessary or advisable, pending receipt of a specific consent from me.

___I, do not give consent for emergency medical treatment/aid in the case of illness or injury during the process of receiving services or while being present on the property of the agency (ECL). In the event of an emergency treatment/aid is required, I wish the following procedures to take place:

_____

_____

_____Date:_____

Signature of Participant (or in event participant is a minor), parent/guardian

| |
|---|

Emergency Contact person Relationship to participant

| |
|---|

Phone Number

### PHOTO AND VIDEO RELEASE

I/we authorize the appropriate use of any photographs, audio or video footage that may capture the image of the participant. These photos may be taken during an event or a class that the participant has enrolled in. Photos or videos may be used on the ECL website, public media, newspapers or magazines.

| |
|---|

Signature of parent/guardian/participant of legal age Date

Participation cannot occur until this form has been completed and signed. If the participant is of legal age (18), he or she may complete this form, if he/she is legally competent to do so. Riding instruction will be under strict supervision, and every effort will be made to avoid any accident. **Warning: Under the Michigan equine activity liability act, an equine professional is not liable for an injury to or the death of a participant in an equine activity resulting from an inherent risk of the equine activity.**

Equine Center for Learning
AT THE LANSING SCHOOL DISTRICT

## HEALTH INFORMATION (PHYSICIANS SIGNATURE REQUIRED FOR ALL STUDENTS WITH DISABILITIES)

| First Name & Initial | Last Name | Email address | Date of Birth (mm/dd/yy) |
|---|---|---|---|
| Address | | Phone Number | Gender M F |
| City, State, Zip Code | | Health Insurance Company | Policy Number |
| Parent/Guardian First Name | Parent/Guardian Last Name | Name of Insurance Policy Holder | |
| Parent/Guardian Address if different than above | | Policy Holder's Employer | |
| City, State, Zip Code | | Name of Emergency Contact other than Parent/Guardian | |
| Parent/Guardian Phone # | Participant Diagnosis/Disability | Phone Number of Emergency Contact | |

Please check Yes or No to the following:

| YES | NO | |
|---|---|---|
| | | Heart disease/Defect/High Blood Pressure |
| | | Fainting/heatstroke/exhaustion |
| | | Seizures: Frequency_____ |
| | | Diabetes: Type I or II |
| | | Concussion/Serious Head Injury |
| | | Visual Impairment |
| | | Hearing Impairment |
| | | Special Diet |
| | | Asthma or Exercise Induced Wheezing |
| | | Tendency to Bleed |
| | | Emotional/Psychiatric/Behavioral Problems |
| | | Immunizations are up to date |
| | | Impairment requiring specialized equipment |
| | | Shunts/Rods |
| | | Urination/Bowel Problems |
| | | Tactile Sensitivities |
| | | Joint Replacement |
| | | Communication Issues |
| | | Major Surgery or Serious Illness |
| | | Allergies |
| | | Balance or Muscle Tone Issues |
| | | Down Syndrome, please list the date of the Ist AtlantoDens Interval X-ray:_____ Result: |
| | | Takes Medications |

For any "YES" responses, please explain here.

### MEDICAL CERTIFICATION SECTION
To be completed by examiner

| | | | |
|---|---|---|---|
| Skin | Head | Eyes | Ears |
| Nose | Mouth/Throat | Neck | Lungs |
| Heart | Abdomen | Extremities | Other |
| Height | Weight | Blood Pressure | |

List concerns/conditions that Beekman Therapeutic Riding Center should be aware of for this Participant:

I have examined the individual named in this application and reviewed the health information provided, and I certify that there is no medical evidence available to me which would preclude this person from participation in an equine activity program under appropriate supervision.

| | |
|---|---|
| Signature of Examiner | Title |
| Printed Name | Date |
| Address | Phone |

Note to Examiner: if the participant has Downs Syndrome it is required that a full radiological exam be conducted which certifies the absence of atlantoaxial instability before they may participate in equine activities. Please note the date of the x-ray and those finding's here.

List medications here. If more than 4, attach a separate sheet.

| Medication Name | Dosage | Time Taken | Date Prescribed |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

| Does the student… | YES | NO | Comments |
|---|---|---|---|
| Have a history of seizures? | | | |
| Follow simple directions? | | | |
| Have speech or language difficulties? | | | |
| Have a fear of animals/horses? | | | |
| Walk independently? | | | |
| Have limited range of motion? | | | |
| Have decreased strength/endurance? | | | |
| Have poor balance (sitting/standing)? | | | |
| Have problems with gross motor skills? | | | |
| Have problems with fine motor skills? | | | |
| Have altered sensation (please specify)? | | | |
| Have heart/circulation problems? | | | |
| Have digestion/elimination problems? | | | |
| Have bone/joint problems? | | | |
| Have allergies or breathing problems? | | | |
| Have emotional/behavioral problems? | | | |

Please mark any of the following that have been a recent or past issue and provide specific comments where applicable. These items will not be used to prevent anyone from participating; rather, they are to assist us in best meeting your needs.

☐ Mental health therapy_____
☐ Legal problems_____
☐ Grief/Loss_____
☐ Trauma_____
☐ Special assistance at school_____
☐ Substance abuse_____
☐ Family problems_____

Special assistance required (ECL cannot provide all of these, but it helps us to plan classes/lessons)

☐ Sign interpretation _____
☐ Service dog assistance_____
☐ Wheelchair assist/transfer_____
☐ Visual assistance/aids _____
☐ Emotional/mental helper_____

Instructor Notes:

_____

_____

_____