HIGH & MIGHTY™
THERAPEUTIC RIDING AND DRIVING CENTER INC.
501 (c)(3)

Dear Parents/Guardians,

We look forward to your child joining High & Mighty's all abilities Horse Play Camp. We offer therapeutic riding, driving and other equine assisted activities to both children and adults. We offer an opportunity to experience our horses both on the ground, under saddle and in the carriage. Our program also incorporates art, music and games while learning from our equine friends.

Safety is always our number one priority. For that reason, we ask you to fill out the attached camp application form as well as the liability and photo release form. In addition, please have your child's Health Care Provider complete and sign the medical history forms.

If you have any questions, feel free to call me at 518-672-4202 or email me at info@high-n-mighty.org. Please also visit our web site at www.high-n-mighty.org to learn more about our organization. Thank you and see you at the farm.

Happy Trails,
Laura Corsun
Founder/Executive Director

High & Mighty Horseplay Camp Application

Date:_____

Participant Name:_____

Date of Birth:_____ Height:_____ Weight:_____ Gender: M____ F ____

School:_____

Parent/Guardian Name:_____

Address:_____

Phone: (H)_____(W)_____(C)_____

Email:_____

Best number to reach you during camp hours:_____

Would you like to receive newsletter via email from High & Mighty? Yes_____ No_____

Emergency Contact #1:_____Relationship:_____

Phone:_____Email:_____

Emergency Contact #2:_____Relationship:_____

Phone:_____Email:_____

Does your child take any medications? If so, please list here.

_____

Does your child have any allergies (food, insect, etc.) or any food restrictions? If so, please list here.

_____

_____

Please list any disabilities/diagnoses or if your child has any medical/psychological conditions (past or present) that we should be aware of. If you have any questions or concerns, please contact your child's health care provider.

_____

_____

_____

Please share with us any additional information (i.e. physical and/or psychosocial development, etc.) that would assist us in better serving your child.

_____

_____

_____

Please describe your child's current skill:

___ Never Ridden ___ Beginner (has only ridden a few times on lead)

___ Intermediate (off lead at the walk, started to trot off lead) ___ Advanced (able to walk/trot/beginning to canter)

Please indicate which week(s) of camp you are interested in from 1-3 (1 being your first week choice)

_____ Week 1	June 25-July 29	Ages 4-6	Monday-Friday 9:00am-1:00pm	$300
_____ Week 2	July 9-July 13	Ages 6-14	Monday-Friday 9:00am-3:00pm	$400
_____ Week 3	July 16-July 20	Ages 6-14	Monday-Friday 9:00am-3:00pm	$400
_____ Week 4	July 23-July 27	Ages 6-14	Monday-Friday 9:00am-3:00pm	$400
_____ Week 5	July 30- Aug 3	Ages 6-14	Monday-Friday 9:00am-3:00pm	$400
_____ Week 6	Aug 13-Aug 17	Ages 14+	Monday-Friday 9:00am-3:00pm	$400
_____ Week 7	Aug 20-Aug 24	Ages 6-14	Monday-Friday 9:00am-3:00pm	$400

Camper's T-Shirt Size:

Childs- ____ Small ____ Medium

Adult- ____ Small ____ Medium ____ Large ____ X-Large

LIABILITY RELEASE -- *REQUIRED*

_____ (Participant's Name) would like to participate in the HIGH & MIGHTY THERAPEUTIC RIDING AND DRIVING CENTER, INC. therapeutic riding program ("Program"). I acknowledge the risks and potential for risks of horseback riding and related equine activities, including grievous bodily harm. However, I believe that the possible benefits to myself/my child/my ward are greater than the risk assumed. I hereby, intending to be legally bound for myself, my heirs and my assigns, executors, and administrators, waive and release forever all claims for damages against HIGH & MIGHTY THERAPEUTIC RIDING AND DRIVING CENTER, INC., its Managing Member, Members, Instructors, Therapists, Aides, Volunteers, Employees and/or any farms, stables, clubs and their respective officers, directors, employees, agents, landowners and members for any and all injures and/or losses I/mychild/my ward may sustain while participating in the Program from whatever cause, including but not limited to, the negligence of these released parties. This hold harmless agreement shall extend to all activities engaged in, including but not limited to, equine-assisted therapy and horseback riding.

I have read and understood the foregoing and fully consent to the provisions contained herein:
_____ Dated:_____
Signature or Signature of parent/legal guardian/conservator of Participant in his/her name

REQUIRED if Participant is under 18
***Required witness signature_____ Dated:_____**

Print Witness Name_____
***Witness must be a non-family member over 18 years of age**

PHOTO RELEASE

For the valuable consideration given and which is hereby acknowledged, the undersigned hereby grants to HIGH & MIGHTY THERAPEUTIC RIDING AND DRIVING CENTER, INC. permission to take or have taken still and moving photographs and films including television pictures of my child/self, _____, and consents and authorizes HIGH & MIGHTY THERAPEUTIC RIDING AND DRIVING CENTER, INC., its advertising agencies, news media, and any other persons interested in HIGH & MIGHTY THERAPEUTIC RIDING AND DRIVING CENTER, INC. and its work, to use and reproduce the photographs, film and pictures to circulate and publicize the same by all means including, without limiting the generality of the foregoing, newspapers, television media, brochures, pamphlets, instructional material, books and clinical material and any other form of media, including High & Mighty's website and facebook page.

With respect to the foregoing matters, no inducements or promises have been made to me/us to secure my/our signatures(s) to this release other than the intention of HIGH & MIGHTY THERAPEUTIC RIDING AND DRIVING CENTER, INC. to use or cause to be used such photographs, films and pictures for the primary purpose of promoting and aiding HIGH & MIGHTY THERAPEUTIC RIDING AND DRIVING CENTER, INC. and its work.

_____I hereby consent to and authorize _____I do not consent to, nor do I authorize
_____ Dated:_____
Signature or Signature of parent/legal guardian/conservator of Participant in his/her name

REQUIRED if Participant is under 18
***Required witness signature_____ Dated:_____**

Print Witness Name_____
***Witness must be a non-family member over 18 years of age**

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501 (C)(3)

Date:_____

Dear Health Care Provider:

In order to safely provide Therapeutic Riding, 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, **when completing this form**, please note whether these conditions are present, and to what degree.

Orthopedic

Atlantoaxial Instability- Include neurologic symptoms
Coxarthrosis
Cranial Deficits
Heterotopic Ossification/Myositis Ossificans
Joint Subluxation/dislocation
Osteoporosis
Pathologic Fractures
Spinal Joint Fusion/Fixation
Spinal Joint Instability/Abnormalities

Neurologic

Hydrocephalus/shunt
Spina Bifida/Chiari II Malformation/Tethered
Seizure

Other

Age- under 4 years
Indwelling Catheter/Medical Equipment
Medications- e.g., 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
Fire Settings
Hemophilia
Medical Instability
Migraines
PVD
Respiratory Compromise
Recent Surgeries
Substance Abuse
Thought Control Disorders
Weight Control Disorders

Thank you very much for your assistance. If you have any questions or concerns regarding this patient's participation in equine assisted activities, please feel free to contact Laura Corsun at High & Mighty Therapeutic Riding and Driving Center, Inc. at 518-672-4202 / info@high-n-mighty.org

Participant's Medical History & Physician's Statement

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: Neurologic Symptoms of Atlantoaxial Instability: Present___ Absent___
AtlantoDens Interval X-rays, date:_____ Result: +____ -____

Please indicate current or past special needs 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			

In my opinion, this patient can participate in riding/driving and other equine assisted activities under appropriate supervision. In conjunction with the riding program. I concur in the referral of the patient to the staff physical therapist for evaluation and/or treatment of his abilities and/or limitations in performing exercises and in implementing an effective therapeutic riding program. Should direct physical therapy services be warranted, the following modalities may be included: Neuromuscular re-education, neuromuscular facilitation, therapeutic exercises and activities, gross and fine motor coordination, sensory integrative activities, ADL training and balance training.

Name/Title:_____ MD DO NP PA Other:_____
Signature:_____ Date:_____
Address:_____
Phone:_____ License UPIN Number_____