



Dear Parents/Guardians,

We look forward to your child joining High & Mighty's all-abilities Horseplay Camp. We offer therapeutic riding, driving and other equine assisted services to both children and adults. Horseplay Camp allows the opportunity to experience our horses both on the ground, under saddle and in the carriage. Our program also incorporates art, music, games and so much more all while learning valuable lessons from our equine friends.

In response to the effects of COVID-19, we adhere to all Federal, NYS and local guidelines and protocols in order to continue placing safety as our number one priority. Despite this, we are always committed to providing an exciting and horse-filled program to our campers!

Please fill out the attached Camp Application, Liability and Photo Release as well as have your child's Health Care Provider complete and sign the medical history form. When submitting your forms, please include a \$150 deposit to hold your child's place in camp. This deposit is nonrefundable and without it your child's spot is not guaranteed.

If you have any questions, feel free to call us at 518-672-4202 or email Rachel at rachel@high-n-mighty.org. To learn more about our programs and organization, visit our website at www.high-n-mighty.org. 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: _____

School: _____

Parent/Guardian Name: _____

Address: _____

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

Email: _____

Occupation (Past and/or present): _____ Employer: _____

Best number to reach you during camp hours: _____

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.

What is your child's t-shirt size?: _____

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) Advanced (able to walk/trot off lead, 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 27-July 1 All Abilities- Ages 7+ Monday-Friday 9am-2pm \$550

Week 2 July 5-July 8 Mini Camp- *Ages 4-6* Tuesday-Friday 9am-1pm \$500

Week 3 July 11-July 15 All Abilities- Ages 7+ Monday-Friday 9am-2pm \$550

Week 4 July 18-July 22 All Abilities- Ages 7+ Monday-Friday 9am-2pm \$550

Week 6 Aug 8- Aug 12 All Abilities- Ages 7+ Monday-Friday 9am-2pm \$550

Week 7 Aug 15-Aug 19 FULL Monday-Friday 9am-2pm \$550

Week 8 Aug 22-Aug 26 FULL Monday-Friday 9am-2pm \$550

LIABILITY RELEASE — REQUIRED

I, _____, 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 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 injuries and/or losses I/my child/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 services 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 Volunteer in his/her/their name

REQUIRED if Participant is under 18 years of age

***Required witness signature** _____ **Dated:** _____

Print Witness Name _____

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

PHOTO AND FIRST NAME RELEASE

I, _____, acknowledge and grant permission to take or have taken still and moving photographs and films including television pictures by HIGH & MIGHTY THERAPEUTIC RIDING AND DRIVING CENTER, INC., of myself, _____, and consent and authorize 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, Facebook, Instagram, and other social media.

Initials: _____

In addition, I give permission and consent to have my first name, _____, listed with any photograph taken of me and used by 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 and 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, Facebook, Instagram, and other social media.

Initials: _____

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, pictures, and first name for the primary purpose of promoting and aiding HIGH & MIGHTY THERAPEUTIC RIDING AND DRIVING CENTER, INC., and its work.

_____ **I consent to and authorize use of photo.** _____ **I do not consent to, nor do I authorize use of photo.**

_____ **I consent to use of first name.** _____ **I do not consent to use of first name.**

Dated: _____

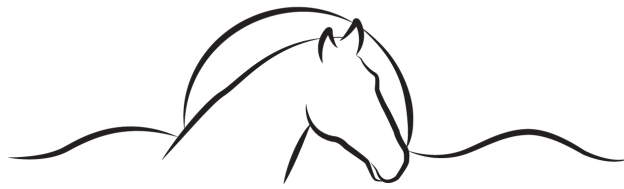
Signature or Signature of parent/legal guardian/conservator of Participant in his/her/their name

REQUIRED if Participant is under 18 years of age

***Required witness signature** _____ **Dated:** _____

Print Witness Name _____

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



HIGH & MIGHTY™

THERAPEUTIC RIDING AND DRIVING CENTER INC.
501 (c)(3)

Date: _____

Dear Health Care Provider:

In order to safely provide equine-assisted activities, 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
Coxarthrititis
Cranial deficits
Heterotopic Ossification/Myositis Ossificans
Joint subluxation/dislocation
Osteoporosis
Pathologic Fractures
Spinal Joint Fusion/Fixation
Spinal Joint Instability/Abnormalities

Neurologic

Hydrocephalus/Shunt
Seizure
Spina Bifida/Chiari II Malformation/
Tethered cord/Hydromyelia

Other

Age-under 4 years
Indwelling Catheters/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 Setting
Hemophilia
Medical Instability
Migraines
PVD
Respiratory Compromise
Recent Surgeries
Substance Abuse
Thought Control Disorders
Weight Control Disorder

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 ___

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 person is not medically precluded from participating in supervised equine activities. I understand that High & Mighty Therapeutic Riding and Driving Inc. will compare the above diagnosis and medical information to the current precautions and contraindications.

Name/Title: _____ MD DO NP PA Other: _____

Signature: _____ Date: _____

Address: _____

Phone: _____ License UPIN Number _____