



Hippotherapy Program

Following is the rider registration packet and schedule for the 2022 season.

- High Horses cannot bill insurance.

About Our Program: High Horses is offering a **six-week** session for winter 2, **Seven-week** sessions for Early Spring, Spring, Summer & Winter 1 and an **eight-week** session for fall. We have a wonderful staff of instructors and therapists along with a herd of kind, gentle horses and incredible volunteers.

- Our Hippotherapy Program is staffed by our team of therapists comprised of Physical Therapists (PT), Occupational Therapists (OT) and Speech Language Pathologists (SLP) or their assistants, and focuses on equine facilitated activities that address physical, occupational, or speech/language challenges. Hippotherapy lessons are private, forty-five minute lessons.

***New Clients must attend a New Client Orientation.** This will be an opportunity to visit the site and meet with an instructor and/or therapist. Please be in touch to schedule a visit before lessons begin. Contact our Program Director at program@highhorses.org or by calling 802-763-3281 for a day & time that is convenient for you.

Our Scheduling/Waitlist Guidelines: High Horses requires:

- All clients submit a fully completed application packet before being considered for scheduling.
- All new clients meet with an instructor or therapist at new rider orientation before being considered for scheduling.

High Horses serves as many clients as we can safely and effectively accommodate. Those that we cannot accommodate, will be placed on our waitlist and will be scheduled as soon as there is an *appropriate opening*. The High Horses staff and medical consultants are happy to discuss options with the riders and/or their families, but reserve the right to make the final decision regarding scheduling and placement.

Depending on a participant's needs and with respect to their safety and for the safety of our staff, volunteers and horses; participants may be scheduled for either private or group lessons, may ride with either a therapist or a certified instructor, or may be offered a spot in our un-mounted program.

An appropriate opening is defined as one where the needs of the client will be safely and effectively met. Variables include the availability of staff, appropriate horse, volunteer assistants, and the client's individual time constraints.

Lesson Policies:

- High Horses does not offer make-up lessons
- Two absences without phone calls by 8am of lesson day may result in a rider being dropped from the program. Please call the barn phone at: 802-763-3281
- Once all riders have been mounted and class has started, latecomers will not be admitted
- If riding lessons cannot be held due to rain or extreme heat, barn lessons will be offered instead
- If a client is dropped from the program before the start of the fourth lesson, a pro-rated refund of the client's fee will be available. After that time, refunds will not be made

Basic Rules for Participants and Visitors:

- Please drive slowly into the facility
- No smoking is allowed on site
- Please walk, use appropriate voices and avoid sudden movements particularly near the horses
- Refrain from using umbrellas near the horses and riding arena
- Do not approach or feed any animals unless accompanied by a High Horses staff or volunteer who has been given explicit permission by the instructor
- Closely supervise riders, siblings of riders, and visitors while waiting in the designated waiting/observation areas
- Remain outside the riding area at all times
- Ask permission from the instructor to take photos or use a flash camera
- Wait for an instructor, or specially trained volunteer to mount or dismount the riders

A caregiver must remain on site while their client is participating in our program. In the rare instance that a client is excused from the ring by the instructor because of behavioral problems or because the client is not feeling well, High Horses cannot maintain responsibility for the care of that client.

Dress requirements:

- Appropriate footwear -Fully enclosed footwear with small flat heel (Ex: Cowboy boot, riding shoe) No Crocs, sandals, flip flops, slippers, clogs or high heels.
- Approved helmet (provided on site)
- Dress for weather conditions

Directions to Our Site:

High Horses TRP is located on 138 Horse Farm Rd, Sharon, VT. Take I 89 to the Sharon exit, take Route 132 to Route 14 then look for Fay Brook Rd. Horse Farm Rd is about a ¼ mile down Fay Brook Rd on Left.



PARTICIPATION GUIDELINES AND POLICIES

1. Referral by agencies, schools, parents, caregivers, self or health professionals must be made.
2. Conditions for Acceptance and Continuation:
 - a. Student shall:
 - 1) Complete all HHTRP enrollment forms annually; medical form MUST be resubmitted after any hospitalization, major illness, surgery, fracture, or seizure.
 - 2) Have sufficient tolerance to benefit from a period of sustained activity and be judged by a High Horses representative to be capable of benefiting from therapeutic riding.
 - b. HHTRP must:
 - 3) Have an appropriate opening for student's age, size and ability.
 - 4) Have a suitable horse available to meet rider's physical requirements (such as height, weight, muscle tone, etc.)
 - 5) Have trained staff capable of mounting and dismounting the rider safely.
 - c. HHTRP waitlist policies apply to all riders.
3. Enrollment and Attendance:
 - a. New students enter under a trial enrollment period of 1-3 classes.
 - b. Students should arrive only early enough to obtain a helmet and be ready at their appointed time.
 - c. Students are expected to attend each class or notify the site coordinator in advance of an absence. (At least a 24-hour notice is requested whenever possible.) Three absences in a session are cause for review of student's placement. One unexcused absence or late arrival is cause for review. Unexcused absences or repeated late arrivals are cause for dismissal from the program.
 - d. High Horses must be notified prior to the lesson day if a student:
 - 1) Has had a seizure since the last lesson.
 - 2) Has been hospitalized for any reason.
 - 3) Has had a change in medication type or dosage that would affect behavior, safety or functioning while in class.
 - 4) Has undergone any change in the information on the medical form.
 - e. Students are required to pay all fees before the session begins. If there are scholarships or third party payers involved, students must notify HHTRP



- f. The adult who is responsible for the client must remain on-site for the duration of the lesson.
4. Contraindications to Participation:
- a. Seizure disorders unless controlled medically.
 - b. Atlanto-axial instability.
 - c. Uncontrolled and/or unmanageable behavior.
 - d. Unstable spine.
 - e. Spontaneous fractures or recent fracture.
 - f. Recent surgery without subsequent physician's release.
5. Mandatory Apparel:
- a. ASTM-SEI approved riding helmet. Helmets will be provided but clients may purchase their own. High Horses staff will verify fit. If the client uses their own helmet, proof of manufactured date is required to verify that the helmet is no more than 5 years old.
 - b. Shoes must have closed toes and heels.
6. Transportation:
- a. Shall be the responsibility of the client.
 - b. Late arrival may result in inability to participate in class.

Contact Information:

PO Box 278
Sharon, VT 05065
802-763-3280
Fax: 802-552-4087
www.highhorses.org



Participant Payment Plan

Rider Fees:

<i>Winter 2 2022 Session</i>	<i>Early Spring 2022 Session</i>	<i>Spring 2022 Session</i>	<i>Summer 2022 Session</i>	<i>Autumn 2022 Session</i>	<i>Winter 1 2022 Session</i>
1/3-2/19 (7 weeks)	2/28-4/16 (7 weeks)	4/25-6/11 (7 weeks)	6/27-8/13 (7 weeks)	8/29-10/22 (8 weeks)	10/31-12/17 (7 weeks)
\$462 Hippotherapy	\$540 Hippotherapy	\$540 Hippotherapy	\$540 Hippotherapy	\$615 Hippotherapy	\$540 Hippotherapy

Name of Participant _____

Name of Parent/Guardian (if applicable) _____

Daytime Phone _____

Evening Phone _____

This Session Will Be Paid By (check all that apply):

- Direct Pay – full payment enclosed
- Direct Pay: send invoice to: _____
Mailing Address: _____
- Partial Scholarship – my application is enclosed
- Third Party – I have contacted the party listed below and have approval.

To verify and arrange for payment please contact:

Agency/School _____

Contact Name _____ Phone# _____

Mailing Address _____

Mail payment to:

**High Horses Therapeutic Riding
PO Box 278
Sharon, VT 05065**



Participant's Application

Check here to denote change in any of the below information

Participant: _____

Diagnosis: _____

DOB: _____ Age: ____ Height: _____ Weight: _____ Gender: M F

Address: _____

Phone: _____ E-mail: _____

Employer/School: _____

Parent/Legal Guardian: _____

Address (if different from above): _____

Phone (if different from above): _____

How did you hear about the program?

The applicant is a new rider and plans to attend the upcoming New Rider Orientation

Medications (include prescription, over-the-counter, name, dose and frequency)

Physical Function (i.e. mobility skills such as transfers, walking, wheelchair use)

Psycho/Social Function (i.e. work/school including grade completed, hobbies, relationships, family structure, support systems, companion animals, fears, etc)

Goals (i.e. Why are you applying? What would you like to accomplish?)

Signature: _____ Date: _____

PHOTO RELEASE:

I DO

I DO NOT

INTEREST IN THE HORSE SHOW

YES

NO

_____ consent to and authorize the use and reproduction by High Horses Therapeutic Riding of any and all photographs and any other audio/visual materials taken of me for promotional material, educational activities, exhibitions or for any other use for the benefit of the program.

Signature: _____ Date: _____

Client, Parent or Legal Guardian



Participant's Medical History & Physician's Statement

(completed by physician)

Participant: _____ DOB: _____ Height: _____ Weight _____
 Address: _____
 Diagnosis(es) _____ 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: AtlantoDens Interval X-Rays, Date: _____ Result: Pos Neg
 Neurologic Symptoms of AtlantoAxial Instability: _____

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			

I have reviewed the list of precautions and contraindications to therapeutic horseback riding as listed on the following page. To my knowledge, there is no reason why this person cannot participate in supervised equine activities. However, I understand that High Horses will weigh the medical information above against existing precautions and contraindications, I concur with a review of this person's abilities/limitations by a licensed/credentialed health professional (e.g. PT, OT, SLP, Psychologist, etc) in the implementation of an effective equine activity program.

- ***I have discussed the particular risks of contracting the covid-19 virus for this particular patient with the patient and family.***

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

(continued)

In order to safely provide this service, our center requests that you complete/update the Medical History and Physician's Statement Form on the previous page. 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. Thank you.

Orthopedic:

Atlantoaxial Instability-include neurologic symptoms
Coxa Arthrosis
Cranial Deficits
Heterotopic Ossification/Myositis Ossificans
Joint subluxation/dislocation
Osteoporosis
Pathologic Fractures
Spinal Joint Fusion/Fixation
Spinal Joint Instability/Abnormalities

Neurologic:

Hydrocephalus/Shunt
Sensory Deficit
Seizure
Spina Bifida/Chiari II Malformation/Tethered Cord/Hydromyelia

Medical/Psychological:

Allergies
Animal Abuse
Cardiac Condition
Physical/Sexual/Emotional Abuse
Blood Pressure Control
Dangerous to Self or Others
Exacerbations of Medical Conditions (i.e. RA, MS)
Fire Settings
Hemophilia
Medical Instability
Migraines
PVD
Respiratory Compromise
Recent Surgeries
Substance Abuse
Thought Control Disorders
Weight Control Disorder

Other:

Age-Under 4 years
Indwelling Catheters/Medical Equipment
Medications-i.e. Photosensitivity
Poor Endurance
Skin Breakdown



Acknowledgement/Assumption of Risk and Liability Release

Name _____ Date of Birth _____ Today's Date _____

Address _____ City _____ State _____ Zip _____

Day Phone _____ Evening Phone _____ Email _____

Emergency contact #1: _____ Contact #1's phone: _____

Emergency contact #2: _____ Contact #2's phone: _____

Acknowledgement/Assumption of Risk

I would like to participate in the High Horses Therapeutic Riding Program (HHTRP). I acknowledge the inherent risks and potential for risks of equine activities and the risks associated with the COVID-19 Coronavirus. However, I assume these risks and feel the possible benefits to me/my son/my daughter/my ward are greater than the risks assumed.

If I have any underlying medical condition, I have discussed restarting my HHTRP program and the risks of contracting the COVID-19 virus with my primary care doctor.

I agree to follow all precautions and procedures that HHTRP mandates to prevent the spread of COVID19.

Warning Under Vermont Equine Activities Law

I further acknowledge that under Vermont law (12 V.S.A. 1039), an equine activity sponsor is not liable for injury to, or the death of, a participant in the equine activities resulting from the inherent risks of equine activities that are obvious and necessary. The term "equine activity sponsor" includes the HHTRP, its employees, volunteers, instructors, therapists, contractors, agents and members of its board of directors.

Liability Release

In consideration for the opportunity to participate in the HHTRP, I release the HHTRP and its employees, volunteers, instructors, therapists, contractors, agents and members of its board of directors from all claims, suits, judgments, losses, and expenses, including those associated with the COVID-19 Coronavirus, arising in whole or in part from my participation in the HHTRP.

Signature: _____ Date: _____

Client, Parent or Legal Guardian



Consent for Release of Information

(Optional)

I hereby authorize the following people to release written and verbal information from the records of _____.

(Participant's name)

The information is to be released to High Horses Therapeutic Riding Program for the purpose of developing a therapeutic riding program for the above named participant.

(Please fill out the name and phone number of those that apply)

Physician (Medical History) Name: _____
Phone Number: _____

Physical Therapist Name: _____
Phone Number: _____

Occupational Therapist Name: _____
Phone Number: _____

Speech Therapist Name: _____
Phone Number: _____

Classroom Teacher Name: _____
Phone Number: _____

Counselor Name: _____
Phone Number: _____

Other Name: _____
Phone Number: _____

This release is valid for one year and can be revoked, in writing, at my request.

Signature: _____ **Date:** _____

Printed Name: _____

A photocopy of this authorization shall have the same validity as the original.



Physician's Prescription for Hippotherapy Program

*** This form is for prospective clients who may receive OT/PT/SLP services
incorporating equine movement. ***

Client's Name: _____

Prescription, where appropriate for evaluation and treatment by a Physical, Occupational
and/or Speech therapist in conjunction with the High Horses Therapeutic Riding Program.

Recommended Frequency: _____

Precautions: _____

ICD-9 Diagnosis code/s: _____

Physician's Signature: _____ **Date:** _____

Physician's Name: _____

Address: _____

Phone: _____



Scholarship Application

To be considered for a scholarship we ask that you provide the following information and that **you have exhausted all other possible funding sources**. Please call if you have any questions regarding our scholarship policy.

Please note - this scholarship application is valid for one year. It will be applied to all sessions you are participating in for the year. If you have more than 3 missed lessons in a single session that are not pre-arranged, your scholarship will be revoked and you will have to wait until the following year to re-apply.

All applications must be completed in full.

1. This application is for (please check one only)
Late Winter ___ Early Spring ___ Spring ___ Summer ___ Fall ___ Early Winter ___
2. How much are you requesting in scholarship support? \$_____ per session
(The maximum possible award is normally 50% of the rider's fee – if you need additional assistance in 2022 due to the COVID-19 Pandemic, please provide a statement of explanation)
3. Have you received scholarship support from High Horses in the past? Yes ___ No ___
4. Annual Taxable Income \$_____ Other Income \$_____
 For verification, please attach a copy of page 1 of your most recent IRS tax return
5. Number of dependents _____
6. Briefly describe any circumstances pertaining to your family and/or finances that might guide the scholarship committee in its decision making process. Please use the back of this form if needed.

Please Note! Applicants must exhaust all applicable funding sources before applying. Please do not assume that award amounts will be the same for each session. Funds for assistance are limited and may vary session to session depending on the number of applicants and their financial need. Notification of awards will be made prior to the start of each session.

Please return this application six weeks prior to the start of the session

Rider's Name _____

Signature of Person Filling Out This Form _____ Date _____

- Reminder: I have attached a copy of page 1 of my most recent IRS tax return