



## Therapeutic Riding

Following is the rider registration packet and schedule for the 2019 season.

- High Horses doesn't bill insurance.

**About Our Program:** High Horses is offering **seven-week** sessions for winter 2, Early Spring, Spring, Summer & Winter 1 and an **eight-week** session for fall. We operate at 138 Horse Farm Road, Sharon, Vermont and have a wonderful staff of instructors and therapists along with a herd of kind, gentle horses and incredible volunteers. We offer five programs:

- Therapeutic riding is taught by our staff of certified instructors and focuses on horsemanship skills that incorporate educational, recreational, and psychosocial goals. Lessons may be private and run for one half hour, or they may be a small group of two or three riders and run for an hour. Our largest program
- Operation Unbridled Freedom offers equine assisted programs for veterans for help in dealing with the physical and psychological effects of war and the after effects of their service time. Working with horses can help people with many types of abilities meet and overcome physical, mental and psychological barriers including PTSD. This program is facilitated by a Marine Veteran. Both our TR program and Operation Unbridled Freedom can be geared for veterans. The VT VA has grants to pay for the 1<sup>st</sup> 10 visits along with grant money for continuing participants.
- Our Hippotherapy Program is staffed by our therapists and focuses on equine facilitated activities that address physical, occupational, or speech/language challenges. Hippotherapy lessons are private, forty-five minute lessons.
- Connections is designed to incorporate a mental health component and runs for one hour. This program is facilitated by a Licensed Social Worker. Great for those suffering from sexual trauma or physical abuse. A female only barn day can be arranged.
- Grey Horse Program is tailored to riders 50 years and over wanting to enjoy horseback riding to increase balance, flexibility and as a form of exercise.

**\*New Riders must attend New Rider Orientation Day.** This will be an opportunity to visit the site and meet with an instructor and/or therapist. Check below for the dates of these events and mark your calendars.

**Lessons Begin            Jan 7            March 4            April 29            July 1            Sept 3            Nov 4**

**Our Scheduling/Wait List Guidelines:** High Horses requires:

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

High Horses serves as many riders as we can safely and effectively accommodate. Those that we cannot accommodate, will be placed on our wait list 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 rider will be safely and effectively met. Variables include the availability of staff, appropriate horse, volunteer assistants, and the rider's individual time constraints.

### **Lesson Policies:**

- Once all riders have been mounted and class has started, latecomers will not be admitted
- Two absences without phone calls by 8am of lesson day may result in a rider being dropped from the program
- If riding lessons cannot be held due to rain or extreme heat, barn lessons will be offered instead
- High Horses does not offer make-up lessons
- If a rider is dropped from the program before the start of the fourth lesson, a pro-rated refund of the Rider'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
- No dogs are 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 rider is participating in our program.** In the rare instance that a rider is excused from the ring by the instructor because of behavioral problems or because the rider is not feeling well, High Horses cannot maintain responsibility for the care of that rider.

### **Dress requirements:**

- Closed toe and closed heel shoes
- Approved helmet (provided on site)
- Shirt

### **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 wait list 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 to mount at 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



## PARTICIPATION GUIDELINES AND POLICIES

- f. The adult who is responsible for the rider 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 riders may purchase their own. High Horses staff will verify fit. If the rider 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 rider.
  - b. Late arrival may result in inability to ride in class.

### **Contact Information:**

PO Box 278  
Sharon, VT 05065  
802-356-3386  
802-763-3280

[www.highhorses.org](http://www.highhorses.org)

Executive Director: Nicole Jorgensen



## Participant Payment Plan

### Rider Fees:

| <i>Winter 2<br/>2019 Session</i> | <i>Early Spring<br/>2019 Session</i> | <i>Spring<br/>2019 Session</i> | <i>Summer<br/>2019 Session</i> | <i>Autumn<br/>2019 Session</i> | <i>Winter 1<br/>2019 Session</i> |
|----------------------------------|--------------------------------------|--------------------------------|--------------------------------|--------------------------------|----------------------------------|
| 1/7-2/22<br>(7 weeks)            | 3/4-4/19<br>(7 weeks)                | 4/29-6/14<br>(7 weeks)         | 7/1-8/16<br>(7 weeks)          | 9/3-10/25<br>(8 weeks)         | 11/4-12/20<br>(7 weeks)          |
| <i>Private ½ hr.</i>             | <i>Private ½ hr.</i>                 | <i>Private ½ hr.</i>           | <i>Private ½ hr.</i>           | <i>Private ½ hr.</i>           | <i>Private ½ hr.</i>             |
| \$350                            | \$350                                | \$350                          | \$350                          | \$400                          | \$350                            |
| <i>Group 1 hr.</i>               | <i>Group 1 hr.</i>                   | <i>Group 1 hr.</i>             | <i>Group 1 hr.</i>             | <i>Group 1 hr.</i>             | <i>Group 1 hr.</i>               |
| \$385                            | \$385                                | \$385                          | \$385                          | \$440                          | \$385                            |

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.

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





## Liability Release

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Today's Date \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Day Phone \_\_\_\_\_

School or Place of Employment \_\_\_\_\_ Evening Phone \_\_\_\_\_

Email address \_\_\_\_\_

In case of emergency contact: \_\_\_\_\_ Phone: \_\_\_\_\_

Emergency contact #2: \_\_\_\_\_ Phone: \_\_\_\_\_

### **Release:**

\_\_\_\_\_ (name) would like to participate in the High Horses Therapeutic Riding Program. I acknowledge the inherent risk and potential for risks of equine activities. However, I feel that the possible benefits to me/my son/my daughter/my ward are greater than the risk assumed.

### **Warning:**

**Under Vermont Law, an equine activity sponsor is not liable for an 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, Pursuant to 12 V.S.A. 1039 – added 1995, No. 136 (ADJ. Sess.), 2. The term “Equine Activity Sponsors” includes High Horses Therapeutic Riding Program, their Board of Directors, Instructors, Therapists, Aids, Volunteers, and/or all Employees.**

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.

High Horses

Therapeutic  
Riding Program



## 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 50% of the rider's fee)
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