Saving Grace Farm

Therapeutic Programs

725 Jackson Road
Salisbury, NC 28146
(704) 209-6577
www.savinggracefarm.com

Dear Parent/Guardian or Participant,

The volunteers and staff at Saving Grace Farm (SGF) look forward to having you participate in our programs. SGF provides therapeutic equine activities to individuals, families, and groups, with all types of special needs and differing abilities. In order to participate, you must complete the attached application forms and send them in to SGF. Please note that one of the forms is a physician's form. SGF requires all applicants with *diagnosed special needs* to obtain a physician's form and statement clearing the participant of any contraindications that might restrict the client's participation in our programs. This packet *must* be completed before the client can *ride* in the program.
*The farm will be required to regretfully decline the client for <u>riding</u>, for the safety of the client, staff, and volunteers if:

- The physician does not clear the client for riding.
- Any form is not completed by the *authorized* individual (i.e. parent, guardian, or physician).
- The student has any condition which could be considered a contraindication (riding would be harmful).
- The instructor finds, that for *any* reason, it would be unsafe for the student, volunteers, staff, and/or horses to accept the client into the program

  ***Please Note**: Students may still be able to participate in ground and classroom activities, even if they are unable to ride. We have many other activities that have a powerful therapeutic effect on individuals. However, if the SGF staff finds that the client may be a danger to themselves or others while on the premises of the farm, the staff reserves the right to remove the client from ground activities as well. *Any client on the <u>premises</u> of the farm must complete a liability release form.* SGF reserves the right to decline/remove a client from activities due to safety or behavior at any time during their relationship with SGF.

Once SGF has received the application, we will schedule an evaluation with you/the client and then consult with you to determine a lesson time for the student each week. Class times and sizes are limited. If we cannot fit the student into the current schedule, they will be placed on a waiting list and we will contact you as soon as an opening becomes available. We will consider those on the waiting list first when scheduling the next session.

Lessons at SGF last approximately 30 to 55 minutes and occur in monthly sessions of 4-8 weeks, with lessons occurring once a week. Out of pocket price for Lesson Tuition is $50/week paid monthly. Sessions are scheduled for Spring, Summer, and Fall. The actual cost of lessons is approximately $130/hr, however we do fundraisers throughout the year so that we may provide scholarship for the difference. We ask that tuition is paid by the last week of the prior month, however payment arrangements can be made. **Scholarships or funding assistance programs are available upon request if you are unable to pay the out-of-pocket rate.** You may ask for the scholarship application from the office. Scholarships are limited and on a first come, first served basis. For information on other funding assistance programs please call our office.

Please return this application to: Attn: Director
Saving Grace Therapeutic Programs
725 Jackson Road
Salisbury, NC 28146

or Fax:
704-603-3022

If you have any questions please feel free to call the Director at 704-209.-6577. Thank you.

Sincerely,
Janna Griggs, Executive Director

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Participant's Application and Health History

Participant: _____
DOB: _____ Age: _____ Height: _____ Weight: _____ Gender: _____ Race: _____
Address: _____
Phone: _____ Email_____ Alternative #: _____
Parent/Legal Guardian: _____
Address (if different from above): _____
Email: _____ Phone: _____
How did you hear about the program? _____

HEALTH HISTORY

Diagnosis/Disability _____
Date of Onset:_____

Please indicate current or past special needs in the following areas:

	Y	N	Comments (please comment for every "yes" answer)
Vision			
Hearing			
Sensation			
Communication			
Heart			
Breathing			
Digestion			
Elimination			
Circulation			
Emotional/Mental Health			
Behavioral			
Pain			
Bone/Joint			
Muscular			
Thinking/Cognition			
Allergies			

MEDICATIONS *(include prescription, over-the-counter; name, dose and frequency)* _____
_____
_____
_____

Describe your abilities/difficulties in the following areas (include assistance required or equipment needed)**:**

PHYSICAL FUNCTION (i.e. Mobility skills such as transfers, walking, wheelchair use, driving/bus riding)_____

_____

_____

PSYCHO/SOCIAL FUNCTION (i.e. performance at work/school including grade completed, leisure interests, relationships-family structure, support systems, companion animals, fears/concerns, etc)

_____

_____

_____

GOALS (i.e. Why are you applying? What would you like to accomplish? Educational, Physical, Mental)

_____

_____

_____

PHOTO/VIDEO RELEASE

I ___DO ___DO NOT

consent to and authorize the use and reproduction by Saving Grace Therapeutic Programs 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. I understand that upon consent the material will only be used in a respectful manner and only by the center named above.

Signature: _____ Date: _____

Client, Parent or Legal Guardian

Confidentiality Policy: I understand that for the purpose of assisting volunteers in providing safe and responsible services to students, Saving Grace Therapeutic Programs will release information pertaining to the student's disability only as deemed necessary by center staff.

Signature: _____ Date: _____

Client, Parent or Legal Guardian

In the event of an emergency, Saving Grace will contact emergency personnel. Please provide info for them:

Physician's Name: _____ Preferred Medical Facility: _____

Health Insurance Company: _____ Policy #: _____

Allergies to medications: _____

Current medications: _____

_____

In the event of an emergency, contact:

Name: _____ Relation: _____ Phone: _____

Name: _____ Relation: _____ Phone: _____

Name: _____ Relation: _____ Phone: _____

*****Confidentiality Agreement*****

I understand that ALL information (written and verbal) about participants at Saving Grace Farm, is confidential and shall not be shared with anyone without the expressed written consent of the participant and/or their parent/guardian in the case of a minor. Every adult that may bring or come with the participant on a regular basis should sign this form.

1. Name: _____

Signature: _____ Date: _____

2. Name: _____

Signature: _____ Date: _____

3. Name: _____

Signature: _____ Date: _____

Please consider having a conversation with children/participants about the importance of confidentiality.

Liability Release Form

CLIENT NAME: _____ AGE: _____

Address: _____ City: _____ State: _____ Zip: _____

PLEASE READ CAREFULLY BEFORE SIGNING

A. I UNDERSTAND THAT Saving Grace Therapeutic Programs (SGF), also known as Saving Grace Farm, Inc. is in an outdoor location in nature with various hazards including, but not limited to: ponds, ditches, steep inclines, animals, insects, poison oak/ivy, snakes, etc. and that there are inherent risks always present in such a location. Knowing these risks, I will be responsible for myself, my children and our own safety.

B. I UNDERSTAND THAT horseback riding and horse activities are classified as a rugged recreational sport activity, and that there are numerous obvious and non-obvious inherent risks always present in such activity despite all safety precautions. I further understand that no horse is completely predictable, and that even well trained horses can become frightened and spook, may divert from its training and act according to its natural survival instincts which may include, but are not limited to: sudden stopping, stopping short, changing directions or speed at will, shifting its weight, bucking, rearing, kicking, biting, or running from danger.

C. I UNDERSTAND THAT SGF is not responsible for total or partial acts, occurrences, or elements of nature that can scare a horse, cause it to fall, or react in some other unsafe way. Some examples are: Thunder, lightening, rain, wind, water, wild or domestic animals, insects, and reptiles.

D. I UNDERSTAND THAT participants must not carry loose items around horses which may fall, blow away, flap in the wind, bounce, or make sharp noises, possibly scaring a horse. Some examples are cameras, hats not securely fastened under chin, toys. Riders should not make sharp, loud noises, such as screaming or yelling, which may scare a horse.

E. I AGREE THAT should emergency medical treatment be required, I and/or my own accidental/medical insurance company **shall pay for all** such incurred expenses. My accidental/medical insurance company is _____ and my policy number is _____.

F. I UNDERSTAND THAT all riders must wear protective headgear.

G. **I AGREE THAT** pursuant to the General Statutes of North Carolina, Chapter 99E, Special Liability Provisions, Article 1, Equine Liability Activity Liability, and under the terms set forth herein, I, the participant (or parent if under 18), and on behalf of my child and/or legal ward, heirs, administrators, personal representatives or assigns, do agree to hold harmless, release, and discharge SGF/Saving Grace Farm, their owners, agents, employees, volunteers, officers, directors and all others acting on their behalf, of and, from all claims, demands, causes of action and legal liability, whether the same be known or unknown, anticipated or unanticipated, due to SGF's and their associates ordinary negligence, and I do further agree that except in the event of SGF's gross negligence and willful and wanton misconduct, I shall not bring any claims, demands, legal actions and causes of action, against this stable and its associates as stated above in this clause, or any economic and non-economic losses due to bodily injury, death, property damage, sustained by me and /or my minor child and/or legal ward in relation to the premises and operations of this control of SGF, whether on or off the premises of this stable.

WARNING

Under North Carolina Law, an equine activity sponsor or equine professional is not liable for an injury to or the death of a participant in equine activities resulting exclusively from the inherent risks of equine activities. Chapter 99E of the North Carolina General Statutes.

I/WE, THE UNDERSIGNED, HAVE READ AND UNDERSTAND THE FOREGOING AGREEMENT, WARNINGS, RELEASE , AND ASSUMPTION OF RISK.

_____ _____

Signature of Participant <u>if over 18</u> (Parent/Guardian if under 18) Date

_____

Home Phone **Business Phone** **Mobile Phone** **Email address**

Saving Grace Farm
725 Jackson Road
Salisbury, NC 28146
Office (704) 209-6577 Fax (704)603-3022
www.savinggracefarm.com

Date: _____

Dear Health Care Provider:
Your patient, _____
(participant's name)
is interested in participating in supervised equine activities at Saving Grace Therapeutic Programs. In order to safely provide this service, 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
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
Seizure
Spina Bifida/Chiari II malformation/Tethered Cord/Hydromyelia

Other
Age - under 4 years
Indwelling Catheters/Medical Equipment
Medications - i.e. 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 (i.e. RA, MS)
Fire Settings
Hemophilia
Medical Instability
Migraine
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 the center at the address/phone indicated above. You may fax this form back to 704-603-3022.

Sincerely,
Janna Griggs, Executive Director

Participant's Medical History & Physician's Statement

(to be completed by a licensed physician)

Please fill this out to its fullest extent

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: **AtlantoDens Interval X-rays, date: _____ Result: + --**
Neurologic Symptoms of AtlantoAxial Instability: ___present ___absent _____% of incidence
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			

Given the above diagnosis and medical information, this person is not medically precluded from participation in equine-assisted activities and/or therapies. I understand that Saving Grace Therapeutic Programs' staff will weigh the medical information given against the existing precautions and contraindications. Therefore, I refer this person to the organization for ongoing evaluation to determine eligibility for participation.

Name/Title: _____ MD DO NP PA Other _____

Signature: _____ **Date**: _____

Address: _____

Phone: (____)_____ License/UPIN Number: _____

Lesson Policy

In order to maximize the number of clients we can help, and offer the best programs possible, we have a few policies in place to aid in our program running more smoothly. We understand that sometimes there are extenuating circumstances and we try to be as considerate of your situation as possible.

- Therapeutic Horsemanship Lessons are **$50 per lesson.** Please pay your first month online in order to place your card on file. After the first month, we prefer future payments be made via check or cash, but online is also acceptable.
- Lesson tuition is due before the first date of service, and then the last lesson of the month for upcoming months thereafter.
- Lessons should be paid for per month. Arrangements may be made for bi-weekly payments with director permission. If payment is not received by the 5th of the month, the card on file will be charged the rate due for that month. To stop or cancel at any time, we ask for a two week notice to avoid being charged for the coming month. You will only be charged what is due (prorated for missed lessons).
- Students should arrive 5 to 10 minutes prior to lessons to ensure they are ready and prepared to begin.
- If a student is going to be late, please contact the instructor/director as soon as possible. Lessons will end on time and being late will reduce the time with your instructor, but calling ahead allows them to be ready for you.
- If a student will be absent for illness or emergency, please notify the instructor immediately. We ask that you give at least a 24 HOUR notice if possible. When given a 24 HOUR notice for a valid reason, the instructor will try to make arrangements to reschedule the lesson. However, if the instructor is not given 24 HOUR advanced notice, and the illness/emergency is not excused by the Director, Saving Grace reserves the right to cancel the lesson and retain the fee. If you do not contact the instructor at least 3 hours prior, we consider this a "no show". Three "no shows" within 6 months will result in dismissal from the program.
- If a lesson is canceled by Saving Grace, we will hold make-up days, or we will offer a credit toward your next month of lessons.
- Students must wear a helmet and closed toed shoes. No crocs, sandals, dress flats, or flip flops. Pants are recommended to prevent saddle rubs. We have helmets here students may use, or you may purchase your own. We recommend having us help determine the fit. It must be an ASTM SEI approved Equestrian helmet.

We will attempt all means necessary to ensure you or your child every opportunity to participate in the programs here at Saving Grace. We simply ask that you offer us as much consideration for our time and programs as we in turn offer you and your family. At Saving Grace, we try to emulate mutual respect and trust, and we hope that you will see this, as you participate in the wonderful programs we have to offer here. Thank you for your participation in the programs at Saving Grace Therapeutic Programs

Janna Griggs
Executive Director

Please detach and return, keep policies for your records

I/We, the undersigned, have received, read and understand the Lesson Policy for Saving Grace Farm and I/We do hereby agree to adhere by these policies. We also understand that Saving Grace has the right to refuse service if we do not follow, within reason, the policies listed.

_____ _____
Signature of rider/guardian if client is under 18 Date

Name of Client _____ DOB _____