East Wellness Equine
& Animal Assisted Therapy

H.O.S.S. Camp Registration

Child Information

Last Name		First Name		Preferred Name	
Gender		Address		Home Phone	

Mother/Guardian Information

Last Name		First Name		Email	
Home Number		Work Number		Mobile Number	
Address					

Father/Guardian Information

Last Name		First Name		Email	
Home Number		Work Number		Mobile Number	
Address					

Emergency Contacts

Contact 1

Last Name		First Name		Relationship to child	
Home Number		Work Number		Mobile Number	
Address					

Contact 2

Last Name		First Name		Relationship to child	
Home Number		Work Number		Mobile Number	
Address					

Contact 3

Last Name		First Name		Relationship to child	
Home Number		Work Number		Mobile Number	
Address					

East Wellness Equine
& Animal Assisted Therapy

H.O.S.S. Camp Registration

Medical Insurance is required for all participants registered for summer camp.
I confirm that the participant has medical insurance.

By signing below, I acknowledge the following:

• that East Wellness Equine & Animal Assisted Therapy provides no insurance coverage for participants;
• that I have read, understand, and agree to the East Wellness Equine & Animal Assisted Therapy Summer Camp Program Policies;
• that I understand I am waiving my legal rights (please refer to camp policies). ???
• that in the event of a medical emergency, every effort will be made to contact parent(s)/guardian(s). I authorize the East Wellness Equine & Animal Assisted Therapy staff to seek appropriate medical care if a parent/guardian cannot be reached;
• that I have selected this summer camp as an appropriate program for the interests and abilities of the participant and that the information I have provided on the Participant Information Form is current and accurate; and
Note: East Wellness Equine & Animal Assisted Therapy staff will only allow the parent/guardian whose signature appears on this registration form to make changes to the form and staff will only release information about the participant to those person(s) listed.

Signature is required to complete the registration process.

_____

Parent/Guardian Name Parent/Guardian Signature Date

Completed Camp Registration Forms can be submitted to East Equine & Animal Assisted Therapy by mailing forms or delivering them to:

East Mental Health
3441 Brandon Avenue, Suite 100
Roanoke, VA 24018

East Wellness Equine
& Animal Assisted Therapy

H.O.S.S. Camp Registration

Participant Information (One form per camper – Copy as needed)

Participant's Name_____

East Wellness Equine & Animal Assisted Therapy welcomes the participation of all individuals in our programs, including those with disabilities. We are fully committed to complying with the ADA and providing reasonable accommodations to facilitate participation in our programs. To ensure that adequate resources are in place, registration should be received at least two weeks prior to the start date of the program.
The City of Raleigh recommends that parents or guardians consult their participant's pediatrician or health care professional to assess their participant's ability to participate in the program. It is requested that parents or guardians provide in writing any additional instructions for the specific condition or special need of their participant.

Health Information

Please indicate YES or NO to ALL items listed. Please use space below to provide additional details on boxes checked Yes.

Additional detailed information for anything checked yes above (including special instructions for allergic reactions): _____
_____
_____
_____
_____

Medication Information

Only medications which are medically necessary and cannot be scheduled outside the hours of the recreation program will be given during the program. No program participant should be in possession of non-prescription or prescription medication of ANY kind without the knowledge of the program staff. Any participant who must receive medication during the program must have on file the appropriate signed medication form:

A. Assisted Administration of Medication: East Wellness Equine & Animal Assisted Therapy staff maintains, provides and monitors consumption of both prescription and non-prescription medication.
B. Self-Administration of Medication: (for use in Teen Programs ONLY) Participant may maintain and consume non-prescription medication, inhalers and/or EPI pen as needed with review from staff.

*****The Assisted Administration of Medication form is included in this packet. Medication forms should be completed and submitted PRIOR to the participant attending camp.**

East Wellness Equine
& Animal Assisted Therapy

H.O.S.S. Camp Registration

Medical Information Continued -

Please list any medication the participant will be taking (during the day at camp and additional information you would like to share): _____
_____
_____
_____

☐yes ☐no Autism Spectrum Disorder (Asperger's, Autism, HFA, PDD)
☐yes ☐no ADHD / ADD (please circle one)
☐Yes ☐no Down Syndrome
☐yes ☐no Emotional / Behavioral Disorder (not related to ADHD/ADD)
☐yes ☐no Epilepsy / Seizures Disorder
☐yes ☐no Intellectual Disability / Developmental Delay
☐yes ☐no Motor Impairment (Cerebral Palsy, Partial Paralysis, etc)
☐yes ☐no Sensory Integration/Processing Disabilities

Height _____ Weight _____ Pulse _____
Blood Pressure _____ Date of Exam _____
Physician Name _____
Phone _____
Address
_____
_____
Physician Signature _____Date _____

☐yes ☐no Allergies: _____
_____
☐yes ☐no Asthma _____
☐yes ☐no Diabetes _____
☐yes ☐no Dietary Restrictions: _____
_____
☐yes ☐no Hearing or Visual Impairment: (glasses, hearing aids, etc.) _____
_____
☐yes ☐no Other Condition: _____

Additional detailed information for anything checked yes above (including special instructions for allergic reactions): _____
_____
_____
_____
_____

East Wellness Equine
& Animal Assisted Therapy

H.O.S.S. Camp Registration

Permission Form for Assisted Administration of Medication

East Wellness Equine & Animal Assisted Therapy employees only administer medication to participants if:

1. The permission form for assisted administration of medication is completed and in the possession of the East Wellness Equine & Animal Assisted Therapy
2. An East Wellness & Animal Assisted Therapy employee will not give medications unless it is in an original container with appropriate medicine contained within, with a visible label including the name of medication, the date of expiration, clear dosage amount and directions with the participant's name CLEARLY INDICATED on the bottle/box.

The Parent/Guardian is responsible for the following with ALL medication:

1. Complete and sign the portion of the form below and return to the program staff.
2. Provide medication in an original container with visible label including the name of medication, the date of expiration, clear dosage amount and administration directions with the participant's name CLEARLY INDICATED. Note: Inhalers outside the original package must be accompanied by a copy of the original package label noting the above information.
3. Provide new, labeled containers if/when medication changes are made.
4. Parents/guardians must transport medication to program site and give directly to program staff.
5. Parent/guardian must pick up medication at the end of each week/program from program staff. Medications not picked up at the end of 14 business days following the last day of participation in the program will be disposed of by program staff.
6. East Wellness Equine & Animal Assisted Therapy program employees will dispose of empty containers (unless otherwise instructed).
7. For prescription medications: The pharmacy label will serve as the physician's authorization for the medication to be administered. Have the pharmacist label two containers: one for home use and one for use in the program, if the participant is to receive medication at both sites.
8. If the medication is an EPI pen or inhaler, it is recommended (not required) that the pharmacist label two containers to keep at the program site. The parent/guardian should check to ensure the medication does not exceed the printed expiration date. Program staff will not accept expired medication.
9. For non-prescription medications: The medication must be administered according to the dosage and administration instructions on the original container.

**A physician's signature will be required as authorization IF medication is requested to be given in an alternate dosage, etc.

10. Parents/guardians should notify program staff as soon as possible if there are any changes to instructions for the administration of medication once this form has been submitted. A new form may be required.

East Wellness Equine
& Animal Assisted Therapy

H.O.S.S. Camp Registration

Permission Form for Assisted Administration of Medication

By completing the information below, the East Wellness Equine & Animal Assisted Therapy staff is authorized to administer any medication(s) that are provided as indicated above.

Participant's Name

_____

1) Name of medication:

_____

Prescription / Non-prescription
Dosage: _____
Times: _____
Reason for Medication: _____
Side effects: _____

2) Name of medication:

_____

Prescription / Non-prescription
Dosage: _____
Times: _____
Reason for Medication: _____
Side effects: _____
Parent/Guardian Signature:

_____

Parent/Guardian Name Parent/Guardian Signature Date

**ONLY under special circumstances for Non-Prescription medications (see #9 above).

_____

Physician Name Physician Signature Date

Parent/Guardian Signature

_____

Parent/Guardian Name Parent/Guardian Signature Date

East Wellness Equine
& Animal Assisted Therapy

EQUINE-ASSISTED ACTIVITIES PROGRAM
Participant Registration and Liability Release Form

Registration

Client: _____ Date of Birth: _____

Street: _____

City: _____ State: _____ Zip: _____

Home Phone:_____ Work:_____ Cell:_____

Parents/Guardian/Spouse: _____ Phone:_____

Street:_____ City:_____ State:_____ Zip:_____

School or Institution presently attending (if applicable):_____

In case of an emergency, Contact: _____ Phone: _____

Contact: _____ Phone:_____

Liability Release

_____ AS A CLIENT OF EAST MENTAL HEALTH , LLC, I ACKNOWLEDGE AND UNDERSTAND THE RISKS AND POTENTIAL RISKS OF INTERACTING WITH HORSES AND HORESBACK RIDING INCLUCING BUT NOT LIMITED TO, (i) THE PROPENSITY OF AN EQUINE TO BEHAVE IN DANGEROUS WAYS, WHICH MAY RESULT IN INJURY OR DEATH TO THE PARTICIPANT OR DAMAGE TO PROPERTY; (ii) THE INABILITY TO PREDICT AN EQUINE'S REACTION TO SOUND, MOVEMENTS, OBJECTS, PERSONS OR ANIMALS; (iii) HAZARDS OF SURFACE OR SUBSURFACE CONDITIONS WHETHER KNOWN OR UNKNOWN; (iv) THE CONDITION AND AGE OF THE EQUIPMENT OR TACK, HOWEVER, I FEEL THAT THE POSSIBLE BENEFITS TO MYSELF/MY SON/MY DAUGHTER/MY WARD ARE GREATER THAN THE RISK ASSUMED. I HEREBY, INTEND TO BE LEGALLY BOUND, FOR MYSELF, MY HEIRS AND ASSIGNS, EXECUTORS OR ADMINISTRATORS, AND WAIVE AND RELEASE FOREVER ALL CLAIMS FOR DAMAGES AGAINST EAST MENTAL HEALTH, LLC AND ITS EMPLOYEES, INSTRUCTORS, THERAPISTS, AIDES, VOLUNTEERS AND THEIR RESPECTIVE FAMILIES, AND CAHAS MOUNTAIN PROPERTIE, LLC AND ITS OWNERS ROBERT M. CALLAHAN AND CAROLYN H. CALLAHAN, FOR ANY AND ALL INJURIES AND/OR LOSSES I MAY SUSTAIN WHILE PARTICIPATING IN EQUINE -ASSISTED ACTIVITIES AND PROGRAMMING OF EAST MENTAL HEALTH, LLC. I FURTHER CERTIFY THAT THE FOREGOING STATEMENTS AND REPRESENTATIONS ARE BEING MADE BY ME KNOWINGLY, FREELY AND VOLUNTARILY, AND I UNDERSTAND THAT EAST MENTAL HEALTH, LLC, IS EXPRESSLY RELYING UPON THE FOREGOING STATEMENTS AND REPRESENTATIONS IN PERMITTING ME TO PARTICIPATE IN EQUINE ASSITED ACTIVITES AND PROGRAMS PROVIDED BY EAST MENTAL HEALTH, LLC.

Date: _____ Signature of Client/Parent or Guardian:_____

PHOTO RELEASE

I CONSENT TO AND AUTHORIZE THE USE AND REPRODUCTION BY EAST MENTAL HEALTH, LLC, OF ANY AND ALL PHOTOGRAPHS AND ANY OTHER AUDIOVISUAL MATERIALS TAKEN OF ME/MY SON/MY DAUGHTER/MY WARD FOR PROMOTIONAL MATERIAL, EDUCATIONAL ACTIVITES, EXHIBITIONS OF FOR ANY OTHER USE FOR THE BENEFIT OF THE PROGRAM.

SIGNATURE: _____DATE_____

PARENT/GUARDIAN:_____DATE_____

East Wellness Equine
& Animal Assisted Therapy

EQUINE-ASSISTED ACTIVITIES PROGRAM

Authorization for Emergency Medical Treatment Form

In the event emergency medical aid/treatment is required due to illness or injury during the process of receiving/giving services, or while being on the property of the agency or boarding facility, I authorize East Mental Health, LLC to:

1) Secure and retain medical treatment and transportation if needed.
2) Release client records upon request to the authorized individual or agency involved in the medical emergency treatment.

Name: _____Phone: _____Cell/work: _____

Address: _____

In the event an emergency occurs, please contact:

Contact/relation: _____Phone:_____

Contact/relation: _____Phone: _____

Allergies: _____

Physician's Name: _____Phone: _____

Preferred Medical Facility:

_____

Health Insurance Co. :* _____

Policy #: _____

**If readily available*

Consent Plan

This authorization includes X-ray, hospitalization, medication and any treatment procedure deemed "life-saving" by the physician. This provision will only be invoked if the person consenting below is non-responsive in a medical emergency.

Date: _____Consent Signature:_____

Client, Volunteer, Parent, or Guardian

Print Name: _____

East Wellness Equine
& Animal Assisted Therapy

H.O.S.S. Camp Registration

Cover Letter to Health Care Provider

**Must be completed by Health Care Provider in order for child to participate in horseback riding activities.

Dear Health Care Provider,

Your patient _____ is interested in participating in supervised
(participant's name)
equine activities that may include horseback riding. In order to safely provide this service, East Wellness Equine & Animal Assisted Therapy requests that you complete 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	**Medical/Psychological**
Atlantoaxial Instability – include neurologic symptoms	Allergies
Coxa Arthrosis	Animal Abuse
Cranial Deficits	Cardiac Condition
Heterotopic Ossification/Mytosis Ossificans	Physical/Sexual/Emotional Abuse
Joint subluxation/dislocation	Blood Pressure Control
Osteoporosis	Dangerous to self or others
Pathologic Fractures	Exacerbation of medical conditions (i.e. RA, MS)
Spinal Joint Fusions/Fixation	Fire Settings
Spinal Joint Instability/Abnormalities	Hemophilia
Neurologic	Medical Instability
Hydrocephalus/Shunt	Migraines
Seizure	PVD
Spina Bifida/Chiari II malformation/Tethered Cord/Hydromyelia	Respiratory Compromise
Other	Recent Surgeries
Age – under 4 years	Substance Abuse
Indwelling Catheters/Medical Equipment	Thought Control Disorders
Medications – i.e. photosensitivity	Weight Control Disorder
Poor endurance	
Skin breakdown	

Thank you for your assistance. If you have any questions or concerns regarding this patient's participation in equine assisted activities, please feel free to contact East Wellness Equine & Animal Assisted Therapy at 540-334-1204.

East Wellness Equine
& Animal Assisted Therapy

Current Medical Status
(Must be completed by Health Care Provider)

Participant:_____ Age:_____

Address: _____
Street City State Zipcode
Diagnoses (if applicable):_____Date of Onset:_____

For persons with Downs Syndrome:
Neurological Exam has been given that specifically denies any symptoms consistent with Atlantoaxial Instability. (AAI)
Date: _____

Tetnus Shot: ☐ Yes ☐ No Date:_____ Height _____ Weight _____
Seizure Type (if applicable):_____ Controlled:_____ Date of last seizure:_____
Medications:_____
_____
_____

***Indicate if patient has a problem and/or surgeries in any of the following areas by checking yes or no.
If yes, please comment.

Areas	Yes	No	Comments
Auditory			
Visual			
Speech			
Cardiac			
Circulatory			
Pulmonary			
Neurological			
Muscular			
Orthopedic			
Allergies			
Learning Disability			
Mental Impairment			
Psychological Impairment			
Other			

Mobility – Independent Ambulation: ☐ Yes ☐ No Crutches: ☐ Yes ☐ No Braces: ☐ Yes ☐ No
Wheelchair: ☐ Yes ☐ No
Please indicate any special precautions:_____
_____
_____

To my knowledge there is no reason why this person cannot participate in supervised equestrian activities. However, I understand that the therapeutic riding center will weigh the medical information above against the 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, Speech, Psychologist, ate.) in the implementing of effective equine assisted activities.

Physician Name (please print):_____
Physician Signature:_____
Address:_____ City:_____ State:_____ Zip:_____
Phone: _____ Date:_____

East Wellness Equine
& Animal Assisted Therapy

H.O.S.S. Camp Registration

Participant Information Survey

Name: _____ Age:_____ Height_____ Weight _____

School: _____ Grade: _____

Physical Limitations (include adaptive equipment used):
_____

Cognitive Limitations (include reading level and number of directions participant can follow):
_____
_____

Behaviors:_____
_____

Sensory Issues:_____
_____

Special Concerns:_____
_____

Interests/Hobbies:_____
_____

Personal Strengths & Attributes:_____

Motivators:_____

Goals:_____

Precautions:_____

Current therapies (if applicable):_____
_____

I release information of this information to the staff and volunteers of East Wellness Equine & Animal Assisted Therapy.

Legal Guardian's Name_____ Date: _____

East Wellness Equine
& Animal Assisted Therapy

H.O.S.S. Camp Registration

Camp Fees and Sponsorships

Camp fee is $350 per camper. To reserve a spot for your camper, please submit a check or money order made out to:

East Mental Health

Checks and money orders should be mailed to:

East Mental Health, LLC
3441 Brandon Avenue, Suite 100
Roanoke, VA 24018
c/o East Wellness Equine & Animal Assisted Therapy
Summer Camp

Camper Sponsorships

A limited number of Full and Partial Sponsorships are available to assist campers who may have limited resources. To apply for a Partial or Full sponsorship, please complete and submit the Sponsorship Application Form (below) to:

East Wellness Equine & Animal Assisted Therapy
3441 Brandon Avenue, Suite 100
Roanoke, VA 24018
Attn: Shelby Ryan

East Wellness Equine
& Animal Assisted Therapy

H.O.S.S. Camp Registration

Confidential Summer Camp Scholarship Application

East Wellness Equine & Animal Assisted Therapy
eastequinetherapy.com- Phone: (540)334-1204 -- Fax:

This form must be completed and mailed in with your 2013 Camp Registration Form

Thank you for applying for a Summer Camp Scholarship. Once we have had a chance to review it, we will contact you with our decision. Scholarships are awarded based on financial need, and we hope to turn no child away due to financial need. However, there are a limited number of scholarships available. Please submit your application as soon as possible.

All areas must be filled out to be eligible for a scholarship. Incomplete applications will not be considered.

Child's Name_____ Birth date_____ Age_____

Child's Name_____ Birth date_____ Age_____

Child's Name_____ Birth date_____ Age_____

Parent/Guardian's Name: _____

Session date for which you are applying: _____

(Girl Power Camp June 25th-June28th; HOSS Camp July 8th-12th; HOSS Camp July 22nd-26th)

East Wellness Equine
& Animal Assisted Therapy

H.O.S.S. Camp Registration

Confidential Summer Camp Scholarship Application
-Continued-

Gross Annual Family Household Income

(Before Taxes):

€ Under $25,000 € $45,000 - $64,999 **Monthly Expenses**: $_____

€ $25,000 - $34,999 € $65,000 – $74,999

€ $35,000 - $44,999 € Over $75,000

Total Number of Individuals in Household: _____ Number of Dependents: _____

How much can you afford to pay for each child per session? Whatever you can afford helps us support more low-resourced children coming to the ranch.

(HOSS Camp- $350/week; Girl Power- $280/4 day camp Tues-Fri)

Amount you can contribute per camp per child: $_____

Please provide us with as much detailed information as possible as to why your family should be eligible for a scholarship. Occupation, employment status/history, extenuating circumstances etc., are all details that are helpful in determining scholarship status. **All information is confidential.**

_____

_____

_____

_____

_____

_____

East Wellness Equine
& Animal Assisted Therapy

H.O.S.S. Camp Registration

Confidential Summer Camp Scholarship Application
-Continued-

_____

_____

_____

_____

_____

_____

_____

_____

_____

If you have any questions about this form, or need to discuss any aspects of summer camp, please call us at 540-334-1204.

****Please note**, arriving more than twenty minutes early or late to either drop off or pick up will result in a $10 fee unless pre-arranged before the start of camp. This fee is not part of the scholarship and the guardian will be responsible for early drop off or late pick up fees.

I attest that the above information is true and correct to the best of my knowledge. If any information changes after this form is submitted, I will contact East Wellness Equine & Animal Assisted Therapy administrative staff to amend any material.

X_____

Parent/Guardian Signature Printed Name Date