Dear Prospective Rider:

We welcome your interest in Wings of Hope Equitherapy! Wings is a 501 (c)(3) non-profit organization, which provides horseback riding instruction and related activities to children and adults with various physical, cognitive, and emotional disabilities.

MISSION STATEMENT
Wings of Hope Equitherapy provides quality equine assisted activities to children and adults with disabilities.

Wings of Hope Equitherapy is a Premier Accredited Center certified by PATH International (Professional Association of Therapeutic Horsemanship International). We maintain the standards of safety, education and animal welfare set forth by that association. Wings of Hope considers the following guidelines when accepting riders:

- **Weight Guidelines:**
  under 5' tall 150 lbs. or less 5'1" --- 5'6" 175 lbs. or less
  5'7" --- 6' 200 lbs. or less 6'1" --- 6'5" 250 lbs. or less

- **Medical History & Physician's Statement:** A rider must not exhibit conditions that are contraindicated as outlined by the PATH International Standards (please see attachment to the Physician's Statement). The Medical History must be **signed** and **dated** by a licensed physician. Riders with Down Syndrome need an "absent" diagnosis of AAI.

- **Entry Interview:** All forms must be completed and returned at the time of the entry interview. Wings of Hope's Program Director or team of Certified Instructors will conduct an Entry Profile and Evaluation. The interviewer must conclude that participation in the program will have a positive impact on the rider. The interviewer may consult with the applicant's physician before the Entry Profile is completed. Please call at the number listed below when the paperwork is completed.

- **Class Schedule:** Riders are assigned to classes based on a rider's age, capabilities, availability of an appropriate horse and the number of volunteers needed for a safe experience. Classes are once a week, and are approximately 45 minutes in length. Class size is limited to four riders. A qualified rider will be assigned to an appropriate class or placed on a waiting list.

- **Cost:** Tuition is $30 per lesson. Lessons are not covered by health insurance, however scholarships are available for families who qualify.

Wings of Hope makes every effort to provide enough volunteers to serve our riders. Unfortunately there are times when, despite our best efforts, we have a shortage of trained volunteers. We are asking families to step in and sidewalk or lead a horse if possible. We understand not everyone can bring a side-walker and Wings will still attempt to provide adequate volunteers for every class. If you have a family member or friend who can assist please have them fill out the enclosed volunteer forms. Your help is greatly appreciated.

Thank you for interest in our program. Please review the GUIDELINES on subsequent pages for further information. We look forward to meeting you and your family.

Sincerely,

Julie Rivard
Director of Operations

WINGS OF HOPE EQUITHERAPY

Participant Application & Annual Renewal Form

Date: _____

General Information:

Participant:_____ **Date of Birth :**_____

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

Home Phone: _____ **Cell Phone:** _____ **Work Phone:** _____

What is the best way to reach you? _____ **E-Mail Address:** _____

Employer/School: _____ **Position/Grade:** _____

Parent/Guardian/Adult Caregiver if applicable: _____

Address if different from above: _____

City: _____**State:** _____ **Zip:** _____

In case of Emergency contact: 1) _____ **Phone:** _____

2) _____ **Phone:** _____

Are you interested in taking part in a weekly prayer group before or after class? ____yes _____no

What are your goals for therapeutic riding? _____

_____

_____

_____

Describe abilities and difficulties. _____

_____

_____

Any comments about physical and/or social function: _____

_____

_____

Additional Comments: _____

_____

WINGS OF HOPE EQUITHERAPY
Authorization for Emergency Medical Treatment for Participant

Participant Name: _____ **DOB:** _____

Address: _____**City:**_____ **Zip** _____

Physicians's Name: _____ **Preferred Medical Facility:** _____

Insurance Carrier: _____ **Policy Number** _____

Emergency Contact: _____ **Relationship** _____

Day Phone: _____ **Evening Phone:** _____ **Cell Phone:** _____

Health History: _____

List allergies to medications: _____

List medications and dosages: _____

Please indicate current or past special needs in the following systems/areas, including surgeries:

Auditory	Y ___	N ___
Visual	Y ___	N ___
Tactile Sensations	Y ___	N ___
Speech	Y ___	N ___
Cardiac	Y ___	N ___
Circulatory	Y ___	N ___

Integumentary/Skin	Y ___	N ___
Immunity	Y ___	N ___
Pulmonary	Y ___	N ___
Neurologic	Y ___	N ___
Muscular	Y ___	N ___
Balance	Y ___	N ___

Allergies	Y ___	N ___
Learning Disability	Y ___	N ___
Cognitive	Y ___	N ___
Emotional/Psychological	Y ___	N ___
Orthopedic	Y ___	N ___
Pain	Y ___	N ___
Other: _____		

In the event emergency medical aid/treatment is required due to illness or injury during the process of instructing, working or while being on the property of the Agency (Wings of Hope), I authorize Wings of Hope Equitherapy to: (1) Secure and retain medical treatment and transportation if needed, and (2) Release any records upon request to the authorized individual or agency involved in emergency treatment.

Consent Plan:
This authorization includes x-ray, surgery, hospitalization, medications and any treatment procedure deemed "life saving" by the physician. This provision will only be invoked if the emergency contact is unable to be reached.

Consent Signature: _____ **Date:** _____
Parent, Guardian or Adult Caregiver signature (needed if under 18 years of age)

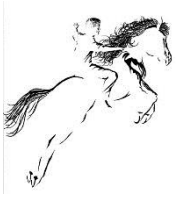
Print Name: _____ Phone: _____

Non-Consent Plan
I do not give my consent for emergency medical treatment/aid in the case of illness or injury during the process of volunteering, receiving services or while being on the property of the agency. In the event emergency treatment/aid is required, I wish the following procedures to take place: _____

Non-Consent Signature: _____ Date: _____
Parent, Guardian or Adult Caregiver signature (needed if under 18 years of age)

Print Name: _____ **Phone:** _____

In non-consent situations Parent, Adult Caregiver or Guardian will remain on site at all times if person is under 18 years of age.



WINGS OF HOPE EQUITHERAPY

Release and Waiver of Liability and Indemnity Agreement

Name: _____ Age if a Minor/Ward: _____

Participant

All equine activities, including the equitherapy program of Wings of Hope Equitherapy, involve inherent risks and dangers which could result in personal injury or death to Participant. I/we acknowledge the risks and dangers of a horse-back riding program to myself or my minor child or ward ("Participant"), but believe that the possible benefits to myself, my child or my ward are greater than the risks and dangers assumed.

UNDER TEXAS LAW (CHAPTER 87, CIVIL PRACTICE AND REMEDIES CODE), AN EQUINE PROFESSIONAL IS NOT LIABLE FOR AN INJURY TO OR THE DEATH OF A PARTICIPANT IN EQUINE ACTIVITES RESULTING FROM THE INHERENT RISK OF EQUINE ACTIVITIES.

WAIVER AND RELEASE OF LIABILITY

I HEREBY EXPRESSLY WAIVE AND RELEASE ANY CLAIM FOR COMPENSATION OR LIABILITY ARISING OUT OF ANY PERSONAL INJURY OR DEATH THAT I, MY MINOR CHILD, OR MY WARD MAY SUSTAIN IN CONNECTION WITH THE WINGS OF HOPE EQUITHERAPY ACTIVITY, REGARDLESS OF WHETHER SUCH PERSONAL INJURY OR DEATH IS CAUSED IN WHOLE OR IN PART BY THE NEGLIGENCE OR FAULT OF WINGS OF HOPE EQUITHERAPY, ITS BOARD OF DIRECTORS, GUARANTORS, INSTRUCTORS, THERAPISTS, AIDES, EMPLOYEES AND VOLUNTEERS ("RELEASEES").

INDEMNITY AGREEMENT

I HEREBY EXPRESSLY AGREE TO INDEMNIFY AND HOLD HARMLESS WINGS OF HOPE EQUITHERAPY, ITS BOARD OF DIRECTORS, GUARANTORS, INSTRUCTORS, THERAPISTS, AIDES, EMPLOUEES OR VOLUNTEERS ("INDEMNITEES") FROM ANY CLAIM FOR PERSONAL INJURY OR DEATH THAT I, MY MINOR CHILD, OR MY WARD MAY SUSTAIN IN CONNECTION WITH WINGS OF HOPE EQUINE THERAPY ACTIVITIES, REGARDLESS OF WHETHER CAUSED IN WHOLE OR IN PART BY THE NEGLIGENCE OR FAULT OF INDEMNITEES.

I understand that Wings of Hope Equitherapy, its Board of Directors, guarantors, instructors, therapists, aides, volunteers and/or employees (Indemnitees/Releasees) will not be legally liable for any personal injuries or death that I, my minor child or my ward might sustain in connection with the Equine Activities regardless of any fault or negligence on the part of Indemnitees or Releasees.

I understand that the waiver and release of liability and the indemnity agreement extend to any and all activities in connection with the Wings of Hope Equitherapy horseback riding program and related activity in which I, my child, or my ward may participate now or in the future.

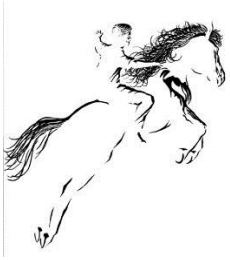
I represent to Wings of Hope that I am the parent or legal guardian of the minor child or ward listed above, and legally authorized to sign this agreement and bind myself and the minor child or ward to this agreement.

Signature: _____ Date: _____

Participant

Signature: _____ Date: _____

Parent/Legal Guardian of minor/ward



WINGS OF HOPE EQUITHERAPY

Confidentiality and Photo/Media Release

CONFIDENTIALITY AGREEMENT:

I understand that all information (written and verbal) about participants at the Wings of Hope Equitherapy PATH International center is confidential and will not be shared with anyone without the expressed permission of the participant and their parent, guardian or caregiver in the case of a minor.

I also understand that all information (written and verbal) regarding mental health information of an Equine Connection Counseling client that may have been obtained by the undersigned is to be kept confidential and that I am not allowed to disclose any information obtained unless (i) authorized by the ECC client in writing, (ii) necessary to maintain someone's personal safety, or (iii) as may be required by law.

Signature: _____ Date:_____
Staff, volunteer, rider, guardian/parent

Wings of Hope Equitherapy will take all precautions to ensure the privacy of our riders, counseling clients, their families, volunteers, and staff members.

PHOTO/MEDIA RELEASE:

I DO ____ DO NOT _____ consent to and authorize the use and reproduction by Wings of Hope Equitherapy of any and all photographs, any audio-visual materials taken of me or spoken/written testimonials for promotional material, education activities, exhibitions or any other use for the benefit of Wings of Hope Equitherapy.

Signature:_____ Date:_____
Staff, Volunteer, Rider, Guardian/Parent

Signature: _____ Date: _____
Parent, Guardian or Adult Caregiver Signature (Necessary if under 18 years of age)

WINGS OF HOPE EQUITHERAPY

Participant Contract

Wings of Hope is a not-for-profit organization that provides recreational therapeutic horseback riding for children and adults with disabilities. Wings of Hope has been in operation since 1996. Our program is a premier accredited center by PATH International, Professional Association of Therapeutic Horsemanship International. All of our Instructors are PATH Certified.

The following are requirements that **must** be read and adhered to while participating in the classes offered at Wings of Hope.

1. Advance payment for classes must be received prior to the first class of the month. Tuition is $120 - $150 per month (based on $30 per class, one class per week, 4 or 5 week month), payable to Wings of Hope Equitherapy by cash, check, or credit card. If you are not in a position to make monthly payments in advance, please contact Wings of Hope to discuss a payment schedule. If the rider's tuition is being funded by a third-party payer, Wings of Hope will invoice the third-party payer. **However, rider or parents/guardians of rider are ultimately responsible for payment.**

**** Please note that all outstanding accounts need to be paid in full prior to starting in September.***

2. If a rider is unable to attend their scheduled class, a 24 hour advance notice is appreciated. If a rider does not give adequate notice or is a "no show," rider will be charged the entire costs for that class. If the rider's tuition is being funded by a third-party payer, the third party payer will not pay for classes and the rider will maintain the responsibility of payment.

   a. Riders with 3 (three) unexcused absences may be removed from the program with the loss of payment received for classes.
   b. Emergency situations are the only exception for not calling to cancel.

3. In the event a rider no longer wants to participate in the program, a one-week notice would be greatly appreciated. This allows Wings of Hope to schedule staff, volunteers and horses accordingly.

4. If Wings of Hope Staff cancels a class session, a credit will be issued to rider. This may be in the form of a refund or payment to be credited to another class.

We are very appreciative of your participation and support of Wings of Hope. Please date and sign below.

_____
Print Name

_____ _____
Signature Date

WINGS OF HOPE EQUITHERAPY

Seizure Disorder Form

Date: _____

Name of Rider: _____

Type of Seizure: _____

Typical motor activity during the seizure: _____

_____

_____

Description of the participant's behavior prior to seizure: _____

_____

Average duration of the seizure: _____

Current frequency of seizures: _____

Date of the last seizure: _____

Description of the rider's behavior during the recovery state, and its duration:

_____

_____

WINGS OF HOPE EQUITHERAPY

Dear Health Care Provider:

Your patient, _____ is interested in participating in supervised equine activities.

In order to safely provide this service, Wings of Hope Equitherapy requests that you complete the Medical History/Physician's Statement Form on reverse. 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/Neurologic
Atlantoaxial Instability - include neurologic symptoms
Coxa Arthrosis
Closed Head Injury
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
TBI –Traumatic Brain Injury

Other
Age - under 4 years
Indwelling Catheters/Medical Equipment
Medications - i.e. photosensitivity
Poor Endurance
Skin Breakdown

Medical/Psychological
Allergies
Animal Abuse
Arson
Cardiac Condition
Physical/Sexual/Emotional Abuse
Blood Pressure Control
Dangerous to self or others
Exacerbations of medical conditions (i.e. RA, MS)
Hemophilia
Medical Instability
Migraines
PVD
PTSD – Post Traumatic Stress Disorders
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 Wings of Hope Equitherapy at the address/phone indicated below.

Sincerely,

Julie Rivard
Director of Operations

WINGS OF HOPE EQUITHERAPY
Participant's Medical History & Physician's Statement

Participant: _____ DOB: _____ Height: _____ Weight: _____

Address: _____

Diagnosis: _____ Date of Onset: _____

Past/Prospective Surgeries: _____

Medications and dosage: _____

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	
Auditory			
Visual			
Tactile Sensations			
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. I understand that the PATH center will weigh the medical information given against the existing precautions and contraindications. Therefore, I refer this person to the PATH center for ongoing evaluation to determine eligibility for participation.

Name/Title: _____ MD DO NP PA Other _____

Signature: _____ Date: _____

Address: _____

Phone: ( ) _____ License/UPIN # _____

PLEASE KEEP FOR YOUR RECORDS

WINGS OF HOPE EQUITHERAPY
GUIDELINES

Lessons: All lessons will be conducted by a qualified, PATH, International trained Instructor, who is also CPR/First Aid certified. The Instructor will work with the rider and his/her family to develop an equine assisted activity plan that may include exercises, horsemanship skills, care of the horse and stable management. Some of this plan may be given in place of a mounted lesson.

Most lessons are approximately 45 minutes in length. In some cases, lesson time may be shortened to accommodate the special needs of a rider. Each rider is evaluated monthly.

Calendar Year: Wings of Hope Equitherapy is open year round. There will be scheduled breaks for holidays, special events, horse rest, and inclement weather. We are closed the months of July & August.

Annual Update of Records: All Riders must resubmit rider packet forms, including Authorization for Emergency Medical Treatment, Physician's Statement/Medical History, and Liability Release.

Tuition: Tuition is $120.00 - $150 per month (based on $30 per session, one session per week, 4 or 5 week month). This fee is payable to Wings of Hope Equitherapy, by cash, check, or credit card. Payment is required on the first of each month. Financial Scholarships are available to qualified families. Contact the office for further information.

Attendance: If you must miss your scheduled class, write it on the big calendar located on the volunteers' sign-in desk in the barn isle, call the office **at least 24 hours prior to class,** or you may email the office **at least 72 hours in advance**. If you have an emergency or are ill, please call the office (817) 790-8810, as soon as possible. Volunteers who give their time each week to assure the safety of our riders are expecting you to be present. When a rider who is scheduled to ride does not show up, the volunteers who were assigned to work with that rider become discouraged and may drop out. This jeopardized the entire program.

Attendance: Instructors will keep attendance records for all riders. Absences that the rider has given 24 hours notice for will be considered "excused." All other absences will be considered "unexcused."

***RIDERS WITH 3 UNEXCUSED ABSENCES WILL LOSE THEIR SPOT IN CLASS AND BE PLACED ON THE WAITING LIST.**

***If you give 24 hours notice, you will be given a credit for the missed class. If you do not give 24 hours notice, NO CREDIT or REFUND will be given.**

Late Rider Policy: It is extremely important for a rider to **arrive 10 minutes prior** to class. If the rider is late to the scheduled time, Wings of Hope cannot guarantee he/she will be able to ride. Once the lesson has begun, the Instructor may not be able to leave the other riders to mount late arriving students. Volunteers will be released 15 minutes after the scheduled start time of the class.

Appropriate Clothing: All riders must wear ASTM/SEI-approved helmets when mounted. Wings of Hope provides these helmets. Riders must wear long pants when using a saddle. All footwear must have closed toes. Hard-soled, sturdy shoes with heels are encouraged.

Weather Conditions: Preexisting: Riding lessons will be canceled ahead of scheduled time. All efforts will be made to contact families prior to that time. **Unplanned:** Should electrical storms, or tornado warnings occur during riding time, classes will be delayed until safe conditions are established.

PLEASE KEEP FOR YOUR RECORDS

Wings of Hope Equitherapy

Safety Rules

All riders, family members, volunteers, staff and guests must comply with all posted safety rules. The Wings of Hope staff requests that all volunteers help to enforce these safety rules.

Safety is our Top Priority!

- NO SMOKING!
  If you want to smoke, you will have to go out the front gate and off the property.
- Observe and obey all posted safety and restricted area signs.
- All persons riding horses will wear ASTM/SEI approved helmets and appropriate foot wear.
- No family pets allowed.
- Family and guests are requested to sit quietly on the bleachers or in the lounge. Please refrain from leaning or climbing on all arena fences.
- The Instructor ONLY will accept treats for the horses. Carrots or apples will be included in their feed. NEVER HAND FEED TREATS TO THE HORSES.
- The mistreatment, abuse, or verbal suggestions of abuse of any one or of any animal **will not** be tolerated!
- Please remember to keep our facility clean be disposing of trash properly.
- No cell phones or pagers inside the arena.
- Parents are responsible for the supervision of their children AT ALL TIMES.