CHEFF THERAPEUTIC RIDING CENTER
CHEFF THERAPY SERVICES

Welcome to Cheff Center. Please read the following general information and guidelines:

- **Paperwork** All forms must be completed and signed prior to starting, *including our Physician Consent form signed by a doctor.* In addition, a physician's prescription is also required for all patients participating in hippotherapy.
- **Payment** Payment in full is expected at the start of each 6-week therapeutic riding session. We bill by the session-not by the week. **No credits or make-ups unless Cheff cancels classes.**
- **Contact** Tamara Homnick, Program Director at 269-731-4471 ext 121 or her email at tam@cheffcenter.org to sign up for an assessment and/or to answer any questions you may have.

We have several programs at Cheff. Please indicate below which program you are interested in:

□ *Therapeutic Riding Lessons*

□ *Hippotherapy – Physical Therapy*

□ *Hippotherapy – Occupational Therapy*

□ *Ground Program (no Physician Consent needed)*

□ *Not sure at this time*

- **General Guidelines**

  - Family and friends of patients are welcome to observe lessons / treatments as long as it is not a distraction. Our lobby has a viewing area to the arena for your comfort.
  - Siblings are welcome at Cheff, but must be under the supervision of an adult at all times.
  - Please leave your pets at home, with the exception of certified service animals.

DISCRIMINATION DISCLOSURE

It is the policy of the Cheff Therapeutic Riding Center to provide equal opportunity for all persons and to prohibit unlawful discrimination because of age, disability, race, color, creed, religion, gender, national origin, or veteran status. This policy applies to all participants, potential participants, volunteers and employees.

IF THE GULL LAKE SCHOOLS ARE CLOSED DUE TO WEATHER, ALL LESSONS AND TREATMENTS ARE AUTOMATICALLY CANCELLED.

Cheff Therapeutic Riding Center
Cheff Therapy Services

Participant Application & Health History

OFFICE USE ONLY

TR ___ Hippo PT ___ Hippo OT ___

Equi-Force ____ Newsletter ____
Email _____ Sandi email _____
Referred by ____ Hippo Ltr ____

GENERAL INFORMATION

Participant name _____ DOB _____ Age _____

Address _____

City _____ State ____ Zip _____ County _____

Gender: M F Height _____ Weight _____*

** 200-pound weight limit variable dependent upon ambulatory status, ROM, and discretion of instructor*

Race/Ethnicity: *American Indian/Alaska Native ____; Asian ____; Black/African American ____; Hispanic/Latino ____; Native Hawaiian/Other Pacific Islander ____; White; ____; Other ____*

This information is optional – for grant purposes only

Parent/Legal Guardian _____

Address (if different from above) _____

Email Address _____

Phone-primary: _____ Phone-other (specify): _____

How did you hear about us?_____

HEALTH HISTORY (attach additional sheet if necessary)

Diagnosis/Disability _____

Other therapies currently received _____

Current medications _____

Psycho-social function (interests, family structure, support system, etc) _____

_____

Please mark any of the following that have been a recent or past issue, and provide specific comments where applicable. These items will not be used to prevent anyone from participating; rather, they are to assist us in best meeting your needs:

- ☐ Mental health therapy _____
- ☐ Legal problems _____
- ☐ Grief/Loss _____
- ☐ Trauma _____
- ☐ Special assistance at school _____
- ☐ Substance abuse _____
- ☐ Family problems _____

Special assistance required (Cheff Center cannot provide these, but it helps us to plan classes/lessons)

- ☐ Sign interpretation _____
- ☐ Service dog assistance _____
- ☐ Wheelchair assist/transfer _____
- ☐ Visual assistance/aids _____
- ☐ Emotional/mental helper _____

Has the student had prior experience with therapeutic riding or hippotherapy? YES NO

If so, when and where? _____

Does the student…	YES	NO	Comments
Have a history of seizures?			
Follow simple directions?			
Have speech or language difficulties?			
Have communication difficulties?			
Have a fear of animals/horses?			
Walk independently?			
Have limited range of motion?			
Have decreased strength/endurance?			
Have poor balance (sitting/standing)?			
Have problems with gross motor skills?			
Have problems with fine motor skills?			
Have altered sensation? (specify)			
Have heart/circulation problems?			
Have digestion/elimination problems?			
Have bone/joint problems?			
Have allergies or breathing problems?			
Have emotional/behavioral problems?			

GOALS

What would you like to accomplish in our program? _____

_____

_____

_____

_____

_____

ADDITIONAL COMMENTS

Please provide any additional information that you feel would be helpful in class selection and lesson planning for this participant _____

_____

_____

_____

_____

_____

Please call the Cheff Therapeutic Riding Center at 269-731-4471 with any questions.

_____ _____

Participant signature Date

_____ _____

Parent/Guardian signature Date

Send completed forms to:

Tamara Homnick, Program Director
Cheff Therapeutic Riding Center
8450 North 43rd Street, Augusta MI 49012
tam@cheffcenter.org fax: 269-731-2990

Cheff Therapeutic Riding Center / Cheff Therapy Services
8450 North 43rd Street, Augusta MI 49012
Tel: 269-731-4471 Fax: 269-731-2990

Physician Consent Form

Participant's name: _____ DOB: _____
Parent/Guardian name: _____
Address: _____ City: _____ Zip: _____
Phone: _____ **CURRENT HEIGHT**: _____ **CURRENT WEIGHT**: _____

200-LB WEIGHT LIMIT DEPENDANT UPON AMBULATORY STATUS, ROM, AND THERAPIST DISCRETION

The Cheff Center is a therapeutic riding program designed to benefit the riders physically, socially, and emotionally. Safety equipment and specially trained horses and volunteers are used. In order to assure the fullest possibly protection and greater personal benefit from the program, each rider is required to furnish the following medical information before being accepted as a riding student.

NOTE: *BECAUSE OF THE NATURE OF THE ACTIVITY OF HORSEBACK RIDING, NO INDIVIDUAL DIAGNOSED WITH DOWN SYNDROME CAN BE ACCEPTED FOR RIDING INSTRUCTION WITHOUT AN ANNUAL MEDICAL CLEARANCE FROM A LICENSED PHYSICIAN THAT INCLUDES A NEUROLOGIC EXAM THAT SPECIFICALLY DENIES ANY SYMPTOMS CONSISTENT WITH ATLANTOAXIAL INSTABILITY (AAI)*

Diagnosis: _____
_____ **Date of onset**: _____

IF DIAGNOSIS IS DOWN SYMDROME, THIS FORM MUST BE ACCOMPANIED BY A SIGNED AND DATED STATEMENT FROM THEIR PHYSICIAN THAT DENIES ANY SYMPTOMS CONSISTENT WITH AAI.

Does this person demonstrate explosive/violent behavior or the potential for explosive/violent behavior? _____ **If Yes, please explain:** _____
_____
_____

Medical History: _____
_____

Surgical Procedures: _____
_____

Medications: _____
_____

Defects present in: ☐Sight ☐Hearing ☐Speech ☐Balance
☐Neuro-sensation ☐Muscle Tone ☐Coordination ☐Mobility

Braces or assisted devices used? ☐ NO ☐ YES: _____

Is the participant ambulatory? ☐ YES ☐ NO

Comment if applicable:
Seizures: _____
Incontinence: _____

General comments: _____
_____

IN MY OPINION THE PATIENT NAMED ABOVE CAN RECEIVE RIDING INSTRUCTION UNDER APPROPRIATE SUPERVISION
Physician signature: _____ Date: _____
Physician's printed name: _____
Address: _____ City: _____ Zip: _____
Phone: _____ Fax: _____

Cheff Therapeutic Riding Center / Cheff Therapy Services
8450 North 43rd Street, Augusta MI 49012
Tel: 269.731.4471 Fax: 269.731.2990

Photo & Emergency Treatment Release

Participant: _____ Date of birth: _____
Disability & date of onset: _____
Parent/Guardian: _____
Address _____
Street City State ZIP
Parent/Guardian's Employer: _____
Primary Email: _____ Other Email: _____

Correspondence will be by Email. Do you prefer we contact you by phone instead?

☐ NO, email works fine for me ☐ YES, contact me via ph# below.
Primary Phone:_____ (who?)_____ Other Phone: _____ (who?)_____

PHOTO RELEASE (Please check one)

I DO-☐ *or* **I DO NOT-☐** **Consent to** and authorize the use and reproduction by CHEFF THERAPEUTIC RIDING CENTER of any and all photographs and any other audio/visual materials taken of me for promotional material, educational activities, exhibits, social media or for any other use for benefit of the program.

EMERGENCY TREATMENT RELEASE

Physician's name: _____ Telephone: _____
Physician's address: _____
Health insurance provider: _____ Policy #: _____
Preferred medical facility: _____
Emergency contact (other than parent/guardian):
Name: _____ Relationship: _____
Phone(primary)_____ (other) _____

ALLERGIES: _____

DESCRIBE ANY MEDICAL CONDITIONS REQUIRING PRECAUTIONS/TREATMENT AND ANY MEDICATIONS WITH DOSAGE: _____
_____

____ I GIVE MY CONSENT: In case of a medical emergency, the undersigned authorizes the Cheff Therapeutic Riding Center to provide such medical assistance as they determine to be necessary. The undersigned authorizes any licensed physician and/or medical facility to provide medical surgical care and/or hospitalization for the participant, including anesthetic, which they determine to be necessary or advisable, pending receipt of a specific consent from the undersigned.

OR

____ I DO NOT GIVE MY CONSENT for emergency medical treatment/aid in the case of illness or injury during the process of 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: _____
_____

No participant can be accepted for riding instruction until this form has been completed and signed. If the participant is of legal age (18), he or she may complete the form if he/she is legally competent to do so. Riding instruction will be under strict supervision, and although every effort will be made to avoid any accident, NO LIABILITY can be accepted by any of the organizations concerned including the Cheff Therapeutic Riding Center.

SIGNATURE: _____ **DATE:** _____
(Participant if legally able or parent/guardian)

Cheff Therapeutic Riding Center / Cheff Therapy Services
8450 North 43rd Street, Augusta MI 49012
Tel: 269.731.4471 Fax: 269.731.2990

Liability Release Form

I agree to the following agreement with the CHEFF THERAPEUTIC RIDING CENTER, a Michigan nonprofit corporation (hereafter referred to as "Center") as a condition for allowing me, and the persons identified below, to enter the Center's premises and surrounding land, be near horses, participate in equine-assisted activities, work near horses, handle horses, use equipment, work with staff and volunteers, and/or receive instruction or guidance in riding, grooming, or handling of horses (these activities will hereafter be referred to in this document as "The Activities").

PARTICIPANT IF 18 OR PARENT/GUARDIAN _____

SPOUSE OR OTHER PARENT _____

HOME ADDRESS_____
Street City ST ZIP

PHONE (Home)_____ (Business)_____ (Cell/Other)_____

I also make this agreement on behalf of the following, who is/are my child/ren or court appointed legal ward(s):

1. _____ Age _____ 2. _____ Age _____
Child's DOB: _____ Child's DOB: _____

All parts of this agreement shall apply to me and shall also apply to the children/legal wards listed above. This Release is intended to be valid and binding at ***all times – now and in the future*** – when Center permits me (directly or indirectly) to engage in any or all of The Activities.

IT IS HEREBY AGREED AS FOLLOWS:

1. I have requested to engage in any or all of The Activities, now and/or in the future
2. *Risks*. I understand that anyone engaging in The Activities can suffer bodily and other injuries. Participation in The Activities involved certain inherent risks and, regardless of the care that is taken, it is impossible to ensure the safety of the participant. **I understand the risks/dangers inherent in The Activities, and I agree to assume them. I am not relying on the Center to list all possible risks for me**.
3. *Waiver and Liability Release*. As consideration for Center allowing me to engage in The Activities at any time and at any location, I agree to assume full responsibility for any and all bodily injuries, losses, or damages that I may sustain. I, for my heirs, administrators, personal representatives, or assigns, release and discharge the CHEFF THERAPEUTIC RIDING CENTER, Cheff Therapy Services, and their employees, assistants, directors, volunteers, land owners, and owners of horses from any and all claims, demands, damages, actions, omissions, suits, or causes of action (present or future).

WARNING

Under the Michigan Equine Activity Liability Act [1994 P.A. 351], an equine professional is not liable for an injury to or the death of a participant in an equine activity resulting from an inherent risk of the equine activity.

IT IS MUTUALLY UNDERSTOOD AND AGREED THAT THE WAIVER AND LIABILITY RELEASE SET FORTH IN THIS DOCUMENT CONSTITUTES A WAIVER OF LIABILITY BEYOND THE PROVISIONS OF THE MICHIGAN EQUINE ACTIVITY LIABILITY ACT, 1994 P.A. 351. BY SIGNING THIS RELEASE, I AGREE NOT TO BRING ANY CLAIM OR SUIT AGAINST CENTER OR PERSONS OR ENTITIES WORKING ON BEHALF OF OR AFFILIATED WITH CENTER ON THE BASIS OF ANY EXCEPTION IN THAT LAW.

4. *Indemnification*. I also agree to indemnify and hold harmless the CHEFF THERAPEUTIC RIDING CENTER, Cheff Therapy Services, and persons or entities working on behalf of or affiliated with the Center against all damages which are sustained or suffered by any third persons. The indemnification shall include reimbursement of Center's attorney fees.
5. *ASTM/SEI Headgear*. CHEFF THERAPEUTIC RIDING CENTER will provide me with an equestrian safety helmet that is ASTM-standard and SEI-certified for use when riding, handling, or near horses. I understand that neither CHEFF THERAPEUTIC RIDING CENTER or its assistants or agents can guarantee the suitability of any helmet provided.
6. *Health and Disabilities*. I understand that Center always recommends that I seek the advice of a physician, and many of The Activities pose special physical risks to the participant and even to the volunteer. I want Center to be aware of the following physical conditions I have that may affect my ability to handle, ride, and/or be near an equine: _____
7. Should I breach this Release (or any part of it) I agree to pay the attorney's fees and court costs related to such breach incurred by Center and/or persons directly affiliated with Center. It is also mutually agreed that any disputes arising under this Release, or any activities that are undertaken pursuant to this document, shall be litigated in a court of proper jurisdiction located in or nearest to Kalamazoo County, Michigan.

SIGNATURE OF CONTRACTING PARTY _____ DATE _____
SIGNATURE OF OTHER CONTRACTING PARTY _____ DATE _____

Date: _____

_____ gives permission to Cheff Therapeutic Riding Center to discuss case, or seek medical records from:

_____,

in order to better understand how to best serve the participant.

(participant)

(parent/guardian)

(witness)

NOTICE OF PRIVACY PRACTICES

CHEFF THERAPEUTIC RIDING CENTER
CHEFF THERAPY SERVICES

8450 North 43rd Street, Augusta, MI 49012
Tel: (269) 731-4471 - Fax: (269) 731-2990
www.cheffcenter.org

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I have been provided with and/or read a copy of the Notice of Privacy Practices for Cheff Therapeutic Riding Center / Cheff Therapy Services.

_____ _____

Signature Date