

## **The Strain Family Equestrian Center, LLC**

Dear Participant,

Thank you for your interest in The Strain Family Equestrian Center Therapeutic Program. Enclosed you will find general information on our program, the application process, and the required application paperwork.

The information you provide on the enclosed forms will assist us with scheduling and determining the goals and the appropriateness of our program for you. Many of our riders come weekly and openings are limited. Please know that we will make every effort to schedule you in at your preferred time and day.

When an opening becomes available, you will be contacted to schedule a pre-riding assessment. A \$40.00 assessment fee, payable in cash or check, is due at the time of assessment.

Should you have any questions regarding the application process, enclosed forms, would like to arrange a visit, please contact me at (413) 569-5797.

Sincerely,

**Christina Strain, LICSW**  
Program Director

**20 Vining Hill Road • Southwick, MA 01077**

**(413) 569-5797**

**[www.strainfamilyequestrian.com](http://www.strainfamilyequestrian.com)**

# Strain Family Equestrian Center, LLC Therapeutic Program

## Application Process & Participation Policies

**Application Process:** Available upon request, Strain Family Equestrian Center (SFEC) provides the required forms for participation, which must be fully completed and accepted by SFEC. The following forms are mandatory prior to participation:

- Registration & Release/Authorization for Emergency Medical Treatment
- Medical History

Each form must be signed by the appropriate party (Note: our Medical History form must be signed by a physician.). We also ask that you please complete the Rider Questionnaire. The Therapist and Mental Health Data Forms only need to be completed if the prospective participant receives those services.

Once all forms have been received, prospective participants will be contacted for a pre-riding assessment conducted by staff. A \$40 assessment fee, payable in cash or check, is due on the scheduled assessment date, prior to enrollment.

**Scheduling:** SFEC offers lessons throughout the year. Lessons are ½ hour private lessons and 45-minute group lessons in length, based on the individual's needs and schedule availability. Usually, participants with similar goals are grouped together. Lessons are scheduled for the same day and time each week. SFEC operates Tuesday, Thursday and Saturdays.

**Attendance:** SFEC expects consistent attendance by all participants. If you are unable to attend a regularly schedule lesson, notification must be made by calling the SFEC office at (413) 569-5797 as soon as the absence is anticipated so we may provide sufficient notice to staff and volunteers.

For safety of our riders during the winter and summer sessions, riders will have the option to cancel with the opportunity to make-up the lesson, if the temperature drops below 35 degrees or rises past 90 degrees. Riders cancelling due to temperature are required to give SFEC 24 hour notice of cancellation or the rider will not be allowed to make-up the lesson. If SFEC has to cancel classes due to some unforeseen circumstance such as inclement weather, there will be a make-up day provided. If SFEC has to cancel, all reasonable attempts will be made to notify participants at least 2 hours prior to the change.

**Attire:** Participants should dress weather appropriate and always wear long pants (even during summer), with sturdy-soled boots or shoes with a heel. Jackets and gloves are required for cold weather, as the indoor arena is not heated.

**Payment:** Lessons are paid at the time of lesson.

## Strain Family Equestrian Center, LLC

### **Statement of Participant Eligibility or Dismissal**

Strain Family Equestrian Center (SFEC) Therapeutic Riding offers services to individuals with special needs. Eligibility for participation in SFEC programs is based solely upon an individual's ability to participate meaningfully and safely, provided the necessary resources are available including: an instructor, horse, volunteers and class availability which meets an individual's needs. Financial consideration is not taken into account in determining the eligibility for participation.

Due to the nature of therapeutic riding and other equine related activities, there are individuals for whom SFECs' programs are deemed inappropriate during the evaluation process and are not accepted for enrollment or not eligible to continue in SFECs' programs. This determination is made on the basis of physical, behavioral and other limitations. Our professional staff provides initial and ongoing evaluations for all prospective and active participants.

Individuals accepted into SFECs' program are required to take part in periodic progress reviews and follow SFECs' rules and procedures. During these reviews, or as the result of unusual occurrences during a program session, the SFECs' professional staff may find that continuance in the program for a given individual is inappropriate. For this reason, SFEC reserves the right to discontinue the participation of an individual in its programs when it is deemed that discontinuance is in the best interests of SFEC and/or the individual concerned.

**SFEC reserves the right to decide we are unable to serve an applicant due to unavailable resource(s) and or/safety concerns including PATH Intl. guidelines relating to contraindications for participation.**

## Strain Family Equestrian Center, LLC

### Registration and Release Form/Authorization for Emergency Medical Treatment

Participant's Name: \_\_\_\_\_ Date of Birth: \_\_/\_\_/\_\_ Age: \_\_\_\_\_

Weight: \_\_\_\_\_ Height: \_\_\_\_\_ Disability: \_\_\_\_\_

School or Institution Presently Attending: \_\_\_\_\_ Teacher's Name: \_\_\_\_\_

Primary Contact Name: \_\_\_\_\_ Relation: \_\_\_\_\_

Mailing Address: Street: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: ( ) \_\_\_\_\_ Cell Phone: ( ) \_\_\_\_\_ E-Mail: \_\_\_\_\_

#### In the event of an emergency

Preferred medical facility: \_\_\_\_\_

Emergency Contact I: \_\_\_\_\_ Relationship: \_\_\_\_\_

Home Ph: \_\_\_\_\_ Work Ph: \_\_\_\_\_ (ext) Cell Ph: \_\_\_\_\_

In the event that emergency medical aid/treatment is required due to illness or injury during the process of receiving services, or while being on the property of the agency, I authorize STRAIN FAMILY EQUESTRIAN CENTER. 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.

#### Consent Plan

This authorization includes x-ray, surgery, hospitalization, medication and any treatment procedure deemed "life saving" by the physician. **This provision will only be invoked if the person(s) listed cannot be reached.** In case of non-consent. Please request non-consent form.

Date: \_\_\_\_\_ Consent Signature: - \_\_\_\_\_

Client, Parent, or Legal Guardian

#### Photo & Publicity Release

\_\_\_\_\_ I hereby consent and authorize \_\_\_\_\_ I do not consent to, nor do I authorize

1) Strain Family Equestrian Center (SFEC) to use my(my child's) photograph or image in its print, online and video publications;  
2) release SFEC, its employees and any outside third parties from all liabilities or claims that I might assert in connection with the above-described activities and 3) waive any right to inspect, approve or receive compensation for any materials or communications, including photographs, videotapes, DVDs, website images or written materials, incorporating photos/images of me(my child). Date: \_\_\_\_\_ Relation to Participant: \_\_\_\_\_

Date: \_\_\_\_\_ Signature: - \_\_\_\_\_

Client, Parent, or Legal Guardian

#### Liability Release (Required):

(Name) would like to participate in SFEC Program. I

acknowledge the risks and potential for risks of horseback riding and related equine activities, including grievous bodily harm. However, I feel that the possible benefits to myself/my child/my ward are greater than the risk assumed. I hereby, intending to be legally bound for myself, my heirs and assigns, executors, and administrators, waive and release forever all claims for damages against SFEC owners, Instructors, Therapists, Aides, Volunteers, and/or Employees for any and all injuries and/or losses I/my child/my ward may sustain while participating in the Program from whatever cause including but not limited to the negligence of these released parties. The undersigned acknowledges that he/she has read this Registration and Release Form in its entirety; that he/she understands the terms of this release and has signed this release voluntarily and with full knowledge of the effects thereof.

Date: \_\_\_\_\_ Signature: - \_\_\_\_\_

Client, Parent, or Legal Guardian

# The Strain Family Equestrian Center, LLC

## Therapeutic Horseback Riding

Date: \_\_\_\_\_

Dear Physician:

Your patient, \_\_\_\_\_ (participant's name) is interested in participating in supervised equestrian activities.

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 therapeutic horseback riding. Therefore, when completing this form, please note whether these conditions are present, and to what degree.

### Orthopedic

Atlantoaxial Instability – include neurological symptoms  
Coxarthrosis  
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 – usually 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 (e.g., RA, MS)  
Fire Settings  
Hemophilia  
Medical Instability  
Migraines  
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 therapeutic equine activities, please feel free to contact the center at the address/phone indicated below.

Sincerely,

Christina Strain, LICSW  
Program Director  
20 Vining Hill Road  
Southwick, MA 01077  
(413) 569-5797

**PARTICIPANT'S MEDICAL HISTORY & PHYSICIAN'S STATEMENT**

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, Diets/Needs/Allergies: \_\_\_\_\_  
 \_\_\_\_\_ May participate in all activities \_\_\_\_\_ May participate except for: \_\_\_\_\_  
 Mobility: Independent Ambulation? Y N Assisted Ambulation? Y N Wheelchair? Y N  
 Braces/Assistive Devices: \_\_\_\_\_

***This participant is up-to-date on all the following routine childhood immunizations :***

Immunization	Y	N	Date:	Immunization	Y	N	Date:
Measles				Hepatitis B			
Rubella				Mumps			
Tetanus				Chicken Pox			
Pertussis				Other:			
Polio							
Diphtheria							
Pneumococcal Conjugate							

***Please indicate current or past difficulties 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			

**IMPORTANT NOTE TO DOCTOR/MEDICAL FACILITY:**

**If you prefer to provide the requested information on your own medical form, we will accept that only when the below release section is completed, signed & dated & your form is stapled to our form.**

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 referral of the patient to a licensed/credentialed health professional (e.g., PT, OT, Speech, Psychologist, etc) in the implementations of an effective equestrian program.

**\*\*FOR PERSONS WITH DOWN SYNDROME:**

Neurologic symptoms of Atlanto Axial Instability:  Present  Not Present

Name/Title: \_\_\_\_\_ MD DO Other: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ License/UPIN Number: \_\_\_\_\_

Strain Family Equestrian Center, LLC  
**Therapeutic Riding Participant Questionnaire**

It is helpful for the staff at SFEC to know your participation goals, interests, and understand your current status prior to developing a program for you. Please complete the following questions.

Name \_\_\_\_\_ DOB \_\_\_\_\_

Disability -----

Posture: -----

Balance \_\_\_\_\_

Movement / Coordination: \_\_\_\_\_

General Attitude & Behavior ----- Perceptual/ Balance Problems \_\_\_\_\_

Communication Challenges& Methods (Verbal, Sign, PEC) ----- Cognitive Abilities (age level, multi step directions) \_\_\_\_\_

What are your goals for the riding sessions (i.e., riding skills, behavioral changes, physical improvements, paying attention). Please be specific \_\_\_\_\_

Any special considerations? (i.e., health, precautions, medications, etc.) \_\_\_\_\_

Describe any previous horseback riding experience \_\_\_\_\_

Areas of interest, games & activities \_\_\_\_\_

Suggestions/Comments: -----

How did you hear about our program? -----

The Strain Family Equestrian Center, LLC  
**Therapist Form (Ot/Pt)**

Please fill in applicable information that may be incorporated into the riding program. Thank you

Name: -----

DOB -----

Diagnosis: -----

Medications: -----

VisualMotor/PerceptualMotor: \_\_\_\_\_ -

Sensory Processing: (areas of concern/sensitivity) ----- Motor Skills: (fine motor, motor planning) \_\_\_\_\_ -

Joint Evaluation: -----

Functional Ability & Reflex Limitations: \_\_\_\_\_ -

Self-Care: -----

Adaptive Equipment (mobility, discreet trial training, ADL, Augmentative communication, PECS, etc.):  
\_\_\_\_\_  
\_\_\_\_\_

Sitting: balance: (include static/dynamic surfaces): \_\_\_\_\_ -

Behavior: -----

Safety Awareness: \_\_\_\_\_ -

Therapy Goals: -----

Successful Intervention Strategies used: (sensory modalities, behavioral, rewards, etc.)  
\_\_\_\_\_  
\_\_\_\_\_

**Primary Therapist Signature:** \_\_\_\_\_ **Today's Date:** \_\_\_\_\_

Print Name/Address/Phone: \_\_\_\_\_  
\_\_\_\_\_

**Please return completed form to: STRAIN FAMILY EQUESTRIAN CENTER, LLC**

**20 Vining Hill Road-Southwick, MA 01077- (413) 569-5797**



# The Strain Family Equestrian Center Mental Health Form

Client's Name: \_\_\_\_\_ Date: \_\_\_\_\_

Treatment Therapist: \_\_\_\_\_ Phone: \_\_\_\_\_

## Presenting Problems

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## Diagnosis

Axis I \_\_\_\_\_  
Axis II \_\_\_\_\_  
Axis III \_\_\_\_\_  
Axis IV \_\_\_\_\_  
Axis V (GAF) \_\_\_\_\_

## History

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## Current Medications

Drug	Dose	Route	Time	Purpose
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

## Psychiatric Treatment History

Diagnosis \_\_\_\_\_

Current Therapy \_\_\_\_\_

Outpatient Therapy \_\_\_\_\_

Inpatient Therapy \_\_\_\_\_

## Directions to:

**THE STRAIN FAMILY EQUESTRIAN CENTER, LLC**  
**20 Vining Hill Road**  
**Southwick, MA 01077**  
**(413) 569-5797**

From I-91 South (approximately 25 minutes from Hartford)

From I-91 North (approximately 20 minutes from Springfield)

- Take Exit 40 (Bradley International Airport Exit) to Route 20 exit (East Granby/Granby)
- Take Route 20 to the center of Granby
- Turn right onto 10/202 North
- 1<sup>st</sup> light in Southwick-turn left onto Vining Hill Road
- 1/3 mile on your right-The Strain Family Equestrian Center