Walk By Faith Therapeutic Riding, Inc.

34211 290th St. SW
Fisher, MN 56723
Phone: (218) 280-3284
www.walkbyfaiththerapeuticriding.com
email paperwork:
walkbyfaiththerapeuticriding@gmail.com

WALK BY FAITH THERAPEUTIC RIDING'S POLICIES

Summer 2021

Session Costs for Therapeutic Riding

Private Lessons = $480 (8 Lessons) Payment Due Prior to 1st Lesson

Payment Policy

- Payments should be received by the due date.
- Special Billing – Please call to let us know what is needed.

Attire Policy

Helmets and boots or tennis shoes are required for all riders.

Absence Policy

Please give 24 hour notice whenever possible, this allows us time to inform staff & volunteers. If the rider is absent, Walk By Faith will not make-up that lesson.

Cancellation Policy

If Walk by Faith cancels lessons, we will do our best to schedule a make-up. There may be instances where we are unable to schedule a make-up due to programming.

Walk By Faith reserves the right to deny participation in any program activity that, in the professional opinion of the Walk By Faith staff, presents a risk to the safety and/or well-being of the horses, staff, volunteers and/or other participants.

I have read and understand the above policies.

Signature ____ Date __________________

Please return to Walk by Faith

Participant Initials______

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2021 Participant's Application and Health History (Page 1 of 2)

Participant: ____ DOB: __________________ Age: ______

Height: _________ Weight: _________ Gender: M F T-shirt size ___________

Home Address: _____________________________________ City: _________________State: ____ Zip:___________ Home Phone:

__________________________________Parent work phone: __________________________________ Parents/Legal Guardian (BOTH

NAMES if applicable):____ Address (if different):

____

Cell Phone:________________________________Email: ____

Referral Source: ____________________________________ Phone: ________________________________

If invoice is to be billed to another source and not the parent/Guardian, please list name and full address below:

____

HEALTH HISTORY

Diagnosis: ____ Date of Onset: __________________

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

	Yes	No	Comments
Vision			
Hearing			
Sensation			
Communication			
Heart			
Breathing			
Digestion			
Elimination			
Circulation			
Emotional/Mental Health			
Behavioral			
Pain			
Bone/Joint			
Muscular			
Thinking/Cognitive			
Allergies			

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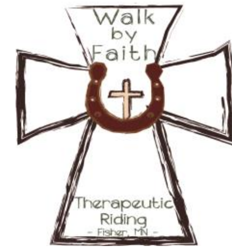


2021 Participant's Application and Health History Cont.' **(Page 2 of 2)**

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)

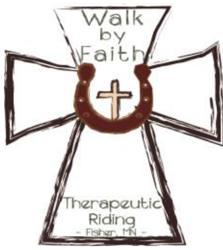
PSYCHO/SOCIAL FUNCTION (i.e. Work/school including grade completed, leisure interests, relationships – family structure, support systems, companion animals, fears/concerns, etc)

GOALS (i.e. Why are you applying for participation? What would you like to accomplish?)

Signature: ____ Date: ___________________

PHOTO RELEASE:
___DO ___DO NOT consent to and authorize the use and reproduction by Walk by Faith 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 (this includes the website and social media).
Signature: ____ Date: ________________
Client, Parent or Legal Guardian

Participant Initials______



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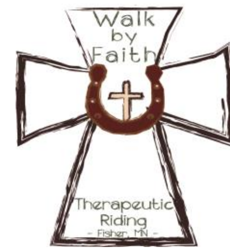

2021 Authorization for Emergency Medical Treatment Form

Participant:____DOB:_______________Phone:____________________

Address:____City:____________________State:____Zip___________

Physician's Name: ________________________________ Preferred Medical Facility: _______________________________

Health Insurance Company: ____________________________________ Policy #: ____________________________________

Secondary Insurance Company (if Applicable):___________________________________ Policy #: _______________________

Allergies :____

Current Medications: ____

In the event of an emergency, contact:

Name:____Relation:_____________ Phone: _________________________

Name: ____ Relation: _____________ Phone:________________________

Name: ____ Relation: _____________ Phone:________________________

In the event 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 Walk by Faith 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.

****PLEASE CHOOSE ONE****

□ Consent Plan

This authorization includes x-rays, surgery, hospitalization, medication and any treatment procedure deemed "life-saving" by the physician. This provision will only be invoked if the person(s) above is unable to be reached.

□ Nonconsent Plan

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:

Date: ______________________ Signature: ____

Client, Parent or Legal Guardian

Participant Initials______

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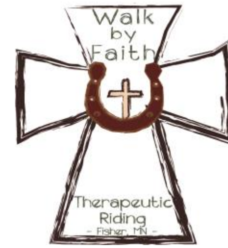

2021 Release and Agreement

1 I, _______________________________________, the undersigned or my minor child, (herein called Releasor), in consideration of being permitted to use the facilities and services of Walk By Faith Therapeutic Riding Inc. for himself/herself, spouse, my minor child, legal representatives, heirs and assigns, HEREBY RELEASES, WAIVES AND DISCHARGES WALK BY FAITH THERAPEUTIC RIDING INC., (HEREIN CALLED RELEASEE) THE OWNERS AND LESSEES OF WALK BY FAITH THERAPEUTIC RIDING INC. INCLUDING TRAVIS SCHWARZ AND KRISTEN SCHWARZ, THEIR AGENTS, EMPLOYEES AND VOLUNTEERS, FROM ALL LIABILITY TO THE RELEASOR, THEIR SPOUSE, LEGAL REPRESENTATIVES,HEIRS AND ASSIGNS, FOR ANY AND ALL LOSS OR DAMAGE, AND ANY CLAIM OR DAMAGES RESULTING THERE FROM ON ACCOUNT OF INJURY TO RELEASOR'S PERSON, EVEN INJURY RESULTING IN DEATH OF THE RELEASOR, WHETHER CAUSED BY THE NEGLIGENCE OF RELEASOR OR OTHERWISE WHILE THE RELEASOR IS RIDING, WORKING, OR FOR ANY PURPOSE USING THE FACILITIES, EQUIPMENT OR SERVICES OF WALK BY FAITH THERAPEUTIC RIDING INC.

2 I agree to indemnify Walk By Faith Therapeutic Riding Inc., Travis Schwarz, Kristen Schwarz and each of them from any loss, damage or cost they may incur due to the participation or use of the facilities, equipment and services of Releasee due to the presence of myself or my minor child in or upon the property owned, located at or controlled by Walk By Faith Therapeutic Riding Inc. whether caused by the negligence of the Releasees or otherwise.

3 I fully understand any involvement with horses involves some risk of harm or injury to myself, my minor child, my horses or my other property and that risk of damage or injury is a normal incident of involvement with horse related activities and I hereby agree that risk is borne by me and/or my minor child and not by Walk By Faith Therapeutic Riding Inc., Travis Schwarz and Kristen Schwarz, or their officers, members, agents, employees or volunteers.

THIS RELEASE CONTAINS THE ENTIRE AGREEMENT BETWEEN THE PARTIES HERETO AND THE TERMS OF THIS RELEASE ARE CONTRACTUAL AND NOT A MERE RECITAL.

I HAVE CAREFULLY READ THE FOREGOING RELEASE AND KNOW THE CONTENTS THEREOF AND SIGNED THIS RELEASE AS MY OWN FREE ACT.

Releasor (Parent/Guardian) ____

Minor Child ___________________________________ Date________________________

Participant Initials______

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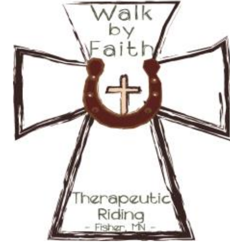


SEND TO PHYSICIAN

2021 Participant's Consent for Release of Information

I hereby authorize: ____
(person or facility)

to release information from the records of: ___________________________________ DOB: __________________
(participant's name)

The information is to be released to Walk by Faith, for the purpose of developing an Equine Assisted Activity/Therapy program for the above named participant. The information to be released is indicated below:

- Medical History
- Physical Therapy evaluation, assessment and program plan
- Occupational Therapy evaluation, assessment and program plan
- Speech Therapy evaluation, assessment and program plan
- Mental Health diagnosis and treatment plan
- Individual Habilitation Plan (I.H.P.)
- Classroom Individual Education Plan (I.E.P.)
- Psychosocial evaluation, assessment and program plan
- Cognitive Behavioral Management Plan

X Attached Participant's Medical History & Physician's Statement, signed & dated

� Other: ____ This

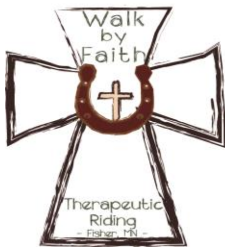
release is valid for one year and can be revoked, in writing, at my request.

Signature: ____ Date: __________________ Print Name:

______________________________________ Relation to Participant: __________________________

Please send materials to:
Walk by Faith
Attn: Kristen Schwarz
34211 290th St SW
Fisher, MN 56723

Participant Initials______



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SEND TO PHYSICIAN Date: ___________________________

Dear Health Care Provider, Your patient, _________________________________(name)
is interested in participating in supervised Equine Assisted Activities/Therapies.

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,

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
Seizures
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
Migraines
PVD
Respiratory Compromise
Recent Surgeries
Substance Abuse
Thought Control Disorders
Weight Control Disorder

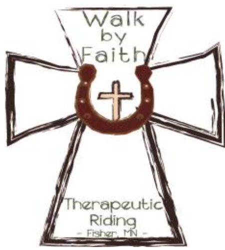
when completing this form, please note whether these conditions are present, and to what degree.

Thank you very much for your assistance. If you have any questions or concerns regarding this patient's participation in our program, please feel free to contact me at the address/phone indicated above.

Sincerely,

Kristen Schwarz, Center Director
Walk by Faith Therapeutic Riding Inc.

Participant Initials______



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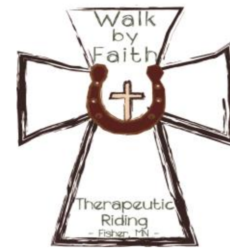

Send to Physician 2021 Participant's Medical History & Physician's Statement **(Page1)**

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

REQUIRED YEARLY FOR **Down Syndrome:** AtlantoDens Interval Xrays Date: __________ Result:__________

Current Neurological Exam:_________Date______Positive Neurologic Symptoms of AtlantoAxial Instability: ________________________

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

	Yes	No	Comments
Auditory			
Visual			
Tactile Sensation			
Cardiac			
Circulatory			
Integumentary/Skin			
Immunity			
Pulmonary			
Neurolgic			
Muscular			
Balance			
Orthopedic			
Allergies			
Learning Disability			
Cognitive			
Emotional/Psychological			
Pain			
Other			

Participant Initials______

Send to Physician **(PAGE 2)**

TO My knowledge, there is no reason why this person cannot participate in supervised Equine Assisted Activities/Therapies. However, I understand that the P.A.T.H. Intl. 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, SLP, Psychologist, etc.) in the implementation of an effective Equine Assisted program.

Name/Title: ____ MD DO NP PA Other ______________

Facility Name:____

Signature: ____ Date: _____________________

Address: ____

Phone: ____ License/UPIN Number: ________________________

Participant Initials______