Back In The Saddle Equine Therapy Center

PO Box 325, Hopkinton, NH 03229
(603) 456-2761 fax: (603) 456-2766
Tax ID: 20-0652400
info@bitsetc.org www.bitsetc.org

PROJECT CONNECT REGISTRATION PACKET

Hello to all BITS ETC Participants,

Thank you for your interest in our Project Connect program. Please fill out this application form for each member of the participating family members completely. Once completed, your spot will be reserved. For your convenience, we accept cash, check (made payable to BITS ETC) or Venmo (@BITSETC). Your prompt payment is appreciated.

Should you need to cancel we ask that you give us at least two days' notice; otherwise, your charge will stand. Missed lessons without notice will be forfeited.

We will notify you in advance if a session must be canceled or rescheduled.

I look forward to seeing you all "back in the saddle!"

Best Regards,

Jaryn Hall-Haines
Executive Director

5 Poverty Plains Road, Warner, NH 03278

BITS ETC General Information

BITS ETC offers therapeutic riding, vocational education, and equine assisted learning Monday through Saturday, year-round.

BITS ETC CONTACT NUMBERS

Office & Barn Number: (603)456-2761

E mail: info@bitsetc.org

Office Secure Fax: (603) 456-2766

Executive Director: Jaryn Hall-Haines (603) 545-5886

Chelsea Coffman, LICSW, Counselor: Licensed Independent Clinical Social Worker offering counseling for the SOAR and Project Connect programs chelsea.c@bitsetc.org

Steve Ofstein, Unmounted instructor Steve.Ofstein@bitsetc.org

BITS BACK IN THE SADDLE ETC EQUINE THERAPY CENTER
www.bitsetc.org • 603-456-2761

PROJECT CONNECT REGISTRATION FORM

Participant Name_____

Primary Contact_____Phone_____

Address [street]_____ [city/zip] _____

E-Mail [please print clearly] _____

Age_____ Height_____ Weight_____

I understand that when all required paperwork has been received (medical clearances) BITS ETC shall contact me to schedule a preliminary visit to establish suitability and schedules.

PHOTO RELEASE

I ❑ DO ❑ **DO NOT** consent and authorize the taking and use / reproduction of any and all photographs, and or other audiovisual materials taken of me by BITS ETC for promotional, (printed, or web-based), exhibitions, educational activities, or for any other use for the benefit of BITS ETC.

Signature: _____ Date: _____
(Parent or Guardian if under 18 years old)

I ❑ DO ❑ **DO NOT** wish to receive emails regarding upcoming events, announcements, fundraisers, etc.

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Help us to learn a little more about you.
This will assist our instructors to better tailor your experience with us.

(To be filled out by client, parent, or guardian)

Participant's Name: _____ Date of Birth: _____

Diagnosis:_____

Allergies:_____

Medications: _____

History of seizures? Yes___ No___ If yes, please explain the type, frequency, and how long it has been since the last seizure occurred. _____

Past Surgeries: _____

_____

Does the participant have any limitations or restrictions regarding movement or activity?

_____

_____

_____

Please list any other precautions we should be aware of: Include physical precautions, behavioral concerns, or any other special considerations.

_____

_____

_____

Is there a crisis plan for the participant? If so, please provide details.

_____

_____

_____

Please note if you have experienced Trauma (if so what kind) and what triggers, if any, that you have. What support do you need in order to have a safe accepting environment?

_____

_____

_____

Goals (Why are you applying for participation? What would you like to accomplish?):

_____

_____

_____

Previous Experience (have you ridden before, or had experiences with horses?)

_____

_____

_____

Describe your abilities/difficulties in the following areas (include assistance required or equipment needed):

Physical Function (mobility skills such as transfers, walking, wheelchair use, driving/bus riding):

_____

_____

_____

Psycho/Social Function (leisure interests, relationships, family structure, support systems, companion animals, fears/concerns, etc.):

_____

_____

_____

Learning Style (How do you, or your child, learn best? Watching someone show you, listening to an explanation, doing the activities matching your body to the instructor's, or figuring something out on your own.):

_____

_____

_____

Other things you would like to share with us:

_____

_____

_____

Signature: _____ Date: _____

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

Name _____DOB_____

Address (street)_____[city/zip]_____

Phone [home]_____[cell]_____Email _____

Physician's Name_____Phone_____

Health Insurance Co _____Policy #_____

Allergies to medications? _____

Current Medications_____

In the event of an emergency, contact:

Name_____Relation_____Phone_____

Name_____Relation_____Phone_____

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

Consent signature_____ Date _____

(Parent or Legal Guardian if under 18)

RELEASE OF LIABILITY

Although every effort will be made to avoid accident or injury, NO LIABILITY can be accepted by BITS ETC, it's officers, board of directors, agents, employees, and any of its members, associates, or the property owners upon whose land the therapeutic riding sessions are conducted.

According to RSA 508:19:

"…an equine activity sponsor, an equine professional, or any other person engaged in an equine activity, shall not be liable for any injury or the death of a participant resulting from the inherent risks of equine activities and, except as provided in paragraph III of this section, no participant's representative shall made any claim against, maintain an action against, or recover from any other person for injury, loss, damage, or death of a participant resulting from any other inherent risks of equine activities. Each participant in an equine activity expressly assumes the risk of and legal responsibility for any injury, loss or damage to person or property which results from participation in an equine activity. Each participant shall have the sole responsibility for knowing the range of his or her ability to manage, care for, and control a particular equine or perform a particular equine activity, and it shall be the duty of each participant to act within the limits of the participant's own ability, to maintain reasonable control of the particular equine at all times while participating in an equine activity, to heed all posted warnings, and to refrain from acting in a manner which may cause or contribute to the injury of any person…"

I have read and understand the legal limits of liability of BITS ETC, and request to participate in therapeutic riding activities as a (**please initial**): _____

I understand the inherent risks and potential for risk of equine activities, and agree to accept them. 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 BITS ETC, its board of directors, instructors, therapists, aides, volunteers, and /or employees for any and all injuries and or losses I (my child, 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 Liability Release 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: _____

Participant [**Please print clearly**]

Signature: _____ Date: _____

(Parent or Guardian if under 18 years old)

CONFIDENTIALITY POLICY

It is the policy of Back In The Saddle Equine Therapy Center to hold absolutely confidential all charts, and communications (oral or written) made by and between or about Therapeutic Riding Center staff, board, volunteers, and clients. It is required that all staff, board members, and volunteers sign this confidentiality agreement. All of these persons are accountable for maintaining the confidentiality of therapy which occurs at BITS ETC. BITS ETC shall treat all communications regarding therapy as protected health information and will be guided by the Federal Health Insurance Portability and Accountability Act (HIPAA) in all dealings with outside agencies or interested persons.

Confidential Communication is any information that is either written or spoken, and shared between client, and / or family-guardian, and staff, volunteers, and board of directors in the course of service delivery of Equine Assisted Therapy and Equine Assisted Learning activities at BITS ETC. The information that is exchanged is considered confidential and is to be kept as such by all involved, and disclosed only to those people who are:

1. Present at the time the information is shared and working to further the interests of the client. 2. Working for BITS ETC, maintaining records of clients for informational purposes (i.e.) to aid in evaluation, and facilitating communications between staff/ volunteers, as well as for medical and psychological documentation.
3. Not associated with BITS ETC, but working on behalf of the client, such as an attorney, counselor, housing worker, or other social service agent.

Maintenance of Records:

1. BITS ETC maintains all records in a strictly confidential manner. Only staff members have access to these records. Clients/guardians may access their records at any time, and copies are available for a nominal copying fee.
2. In cases where information must be disclosed to others, BITS ETC must have a signed release form on file from the client or guardian before said information is disclosed.

(over for signature)

CONFIDENTIALITY POLICY (continued)

Exceptions for the Release of Information:

1. Where a staff member or volunteer has reason to suspect a person has been either physically or sexually abused, a report must be made to the appropriate authority. If a volunteer suspects abuse, they should notify a staff member who will be responsible for reporting such. If the client is willing to report the abuse themselves, BITS ETC will have complied with the requirements for reporting. If they assist that individual with making the report.
2. In criminal proceedings, when the court has determined, through the procedure explained in RSA 173-c, that the information contained in the record or testimony is admissible under chapter 173-c, where medical emergency exists and the information from the file is required and the client/family/guardian is unable to authorize the release, information limited to the medical emergency will be **disclosed to any emergency personnel, and / or the medical institution treating the client.**

I [please print name]_____
have read and agree to abide by the confidentiality policy of BITS ETC.

Signature: _____ Date: _____
(Parent or Guardian if under 18 years old)

New Hampshire Reporting Policy

New Hampshire law mandates that any person who has reason to suspect that a person is being abused or neglected must make a report to the police or State agencies. All employees, contractors, volunteers, interns, and work study students must report every incident of observed, reported, or suspected abandonment, abuse, neglect or self-neglect of clients, as well as injuries of unknown origin.