APPLICATION FOR EQUINE ASSISTED LEARNING (HOPE EAL Program-Adult Group)

Dear Applicant:

We are excited that you are interested in the programs at Dream Catchers. Dream Catchers is accredited as a premier center by the Professional Association of Therapeutic Horsemanship International (PATH Intl.) and has been providing services since 1993. Dream Catchers at the Cori Sikich Therapeutic Riding Center enriches the lives of children, adults, and families through equine assisted activities and therapies offering education, empowerment, healing, and hope.

Dream Catchers Applicant Eligibility Guidelines

- Dream Catchers programs are based on an individual's ability to participate safely and effectively and be compliant with the PATH Intl. standards. Enrollment is offered when the necessary resources are available including: an appropriate horse, volunteers, and a class suitable to the participant's needs.
- Age: 4 years or older
- Weight for mounted activities: Maximum weight is 225 pounds (assuming Dream Catchers has a horse available to meet this need)
- Postural Control: Riders over 80 pounds must be able to maintain a sitting position; at least by holding on with one hand
- Forms: Registration forms must be renewed annually by all participants who are actively participating in Dream Catchers programs.

To apply please take the following steps:

- Fully complete the attached Application and Physician Release
- Mail, fax, or email the completed forms to Dream Catchers
  - Mail: Dream Catchers / PO BOX 1261 / Williamsburg, VA 23187
  - Fax: 757-566-1772, Attention: Beth Yurkovac
  - Email Beth Yurkovac at: byurkovac@dreamcatchers.org

- Please contact our Programs Office at (757) 794-3262 or email at byurko)vac@dreamcatchers.org if you have any questions.

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GENERAL INFORMATION

(This section is to be completed by the Applicant)

Applicant Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: (H) _____ (C) _____ (W) _____

Height: _____ Weight: _____ Date of Birth: _____ Sex: □M □F

Other Gender Preference: _____

Email Address: _____

Are you, a parent, or grandparent active-duty military or retired military? □ YES □ NO

How did you hear about our program? _____

I am able to wear a face covering (please check one): □ YES □ NO

I would be willing to learn how to sidewalk in order for my child to ride or return sooner if they are unable to wear a face covering: □ YES □ NO

Please answer the following questions in order to help us determine a day and time that best suits your needs:

I prefer the: □ Morning □ Afternoon

My preferred day of the week is: □ Monday □ Tuesday □ Wednesday □ Thursday □ Saturday

Please let us know any other scheduling preferences or needs you may have: _____

_____

_____

APPLICATION FOR EQUINE ASSISTED LEARNING (HOPE EAL Program-Adult Group)

Goals:

Please describe experience or previous/current interactions with horses and/or other animals: _____

Communication: (Verbal / Non-Verbal / Sign Language / Learning/Communication Devices/Other):_____

Function: Mobility skills such as transfers, walking, wheelchair use, driving/bus riding. _____

Social: (Work/school activities, including grade completed, leisure interests, relationships, family structure, support systems, companion animals, fears/concerns, etc.) _____

Other Goals: What would you like to accomplish? _____

APPLICATION FOR EQUINE ASSISTED LEARNING (HOPE EAL Program-Adult Group)

Please share anything else you would like us to know:_____

_____

_____

_____

_____

_____

_____

_____

CONFIDENTIALITY POLICY

Maintaining the confidentiality of our participants' medical and sensitive information is of utmost importance to the staff at Dream Catchers. Participants and their families have a right to privacy that gives them control over the dissemination of their medical or other sensitive information. Dream Catchers staff and volunteers will preserve this right of confidentiality for all individuals in its program. DC staff, volunteers, and workshop participants will keep confidential all medical, social, referral, personal, and financial information regarding a person and his/her family. All participants, their families, volunteers, employees, and guests have a right to confidentiality. Equine Facilitated Psychotherapy and Speech services are medical services and federal confidentiality regulations apply for participants in these services. Anyone who works, volunteers for, participates in, or provides services to Dream Catchers is bound by this policy. This includes, but is not limited to, full and part time staff, independent contractors, temporary employees, volunteers, and guests. In effect, this policy applies to anyone connected to Dream Catchers who could obtain medical/sensitive information accidentally or purposely. Confidentiality includes photographic/video imaging. I affirm that I understand this policy in its entirety and I agree to comply.

Signature:_____ **Date:**_____

Applicant (if 18 or older), Parent or Legal Guardian

MEDIA/ VIDEOGRAPHY / IMAGING RELEASE

☐ *I DO*

☐ *I DO NOT*

consent to and authorize the use and reproduction by *Dream Catchers* of any and all photographic, any other audio/visual materials taken of me and/or my child or the participant for whom I am the legal guardian of, and any artwork produced by me and/or my child or the participant for whom I am the legal guardian of or other family members for promotional material, educational activities, and exhibitions or for any other use for the benefit of the program.

Signature: _____ **Date:** _____

Applicant (if 18 or older), Parent or Legal Guardian

APPLICATION FOR EQUINE ASSISTED LEARNING (HOPE EAL Program-Adult Group)

MEDICAL HISTORY/PHYSICIAN RELEASE

Phone: 757-566-1775 Fax: 757-566-1772

(Physician must complete and sign Pages 5 and 6 of this application)

Applicant Name: _____ **Date:** _____

Address: _____

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

Height: _____ **Weight:** _____ **Date of Birth:** _____

Primary Diagnosis: _____ **ICD10 Code:** _____

Onset (please check one): ☐ **Birth** ☐ **Childhood** ☐ **Adolescence** ☐**Adult**

Secondary: _____ **ICD 10Code:** _____

Tertiary: _____ **ICD 10Code:** _____

*****Please answer the following questions for participants with Down Syndrome*****

Atlantodens Interval X-Ray Results: ☐ POSITIVE ☐ NEGATIVE X-Ray Date: _____

Neurological Symptoms of Atlantoaxial Instability? ☐ YES ☐ NO

Please provide a copy of negative X-Ray Results when returning application to Dream Catchers

PLEASE LIST ALL CURRENT MEDICATIONS (Additional medications can be listed on separate paper)

1. _____ Taken For _____
2. _____ Taken For _____
3. _____ Taken For _____

Ambulatory: ☐ YES ☐ NO Uses: ☐ Crutches ☐ Braces ☐ Cane ☐ Walker ☐ Wheelchair

Special precautions needed with this applicant: _____

Please answer the following medical questions:

Question	Answer
Does the applicant have seizures?	☐ YES ☐ NO
• Are seizures controlled?	☐ YES ☐ NO
• Type of Seizure	
• Date of Last Seizure	
Does the applicant have any indwelling medical devices?	☐ YES ☐ NO
• Please list devices if applicable	

APPLICATION FOR EQUINE ASSISTED LEARNING (HOPE EAL Program-Adult Group)

Please CHECK if the following APPLIES to applicant: _____

Print Applicant's Name

Please indicate if any of the conditions below are present and to what degree.

DR	*System Area*		*DR*	*System Area*
	Allergies (incl. asthma)			**Spinal Joint Fusion/Fixation**
	Hearing Impaired / Sensitivity			**Spinal Joint Instability/Abnormalities**
	Balance			**Hydrocephalus/Shunt/Shunt revision**
	Cardiac			**Paralysis Due to Spinal Cord Injury**
	Circulatory / Blood Pressure Control			**Spinal Bifida/Chiari II Malformation/Tethered Cord/Hydromyelia**
	Cognitive Impairment			**Stroke**
	Emotional/psychological			**Indwelling catheters/medical equipment**
	Immunity			**Medication side effects**
	Skin Break Down			**Allergies**
	Learning Disability			**Animal Abuse**
	Muscular			**Cancer**
	Neurological Condition			**Physical/Sexual/Emotional Abuse History**
	Orthopedic Condition			**Dangerous to Self or Others**
	Pulmonary			**Fire setting**
	Speech Impairment			**Hemophilia**
	Tactile Sensation Impairment			**Medical Instability**
	Visual Impairment			**Migraines**
	Atlantoaxial Instability-include neurologic symptoms			**Peripheral Vascular Disease**
	Coxa Arthrosis			**Compromised Respiratory**
	Cranial Deficits			**Recent Surgeries- List**
	Heterotopic Ossifications/Myositis Ossificans			**Substance Abuse**
	Internal Spinal Stabilization Device			**Thought Control Disorders**
	Joint subluxation/dislocation			**Weight Control Disorders**
	Pathological Fractures			**Body Temperature Deregulation**
				Allergy to Bee Stings

To my knowledge, there is no reason why this person cannot participate in supervised equestrian activities. I understand that the therapeutic riding center will weigh this medical information against the existing precautions and contraindications. Therefore, I refer this person to the therapeutic riding center for ongoing evaluation to determine eligibility for participation.

Physician's Printed Name:_____

Title: MD / DO / NP / PA / Other:_____ License/UPIN#:_____

Physician's Signature:_____ Date:_____

Address:_____

City:_____ State:_____ Zip:_____

Office Phone #:_____ Office Fax #:_____

APPLICATION FOR EQUINE ASSISTED LEARNING (HOPE EAL Program-Adult Group)

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

Name:_____ DOB:_____

Address:_____

City: _____ State:_____ Zip:_____

Phone #'s: (H):_____ (C):_____ (W):_____

In the event of an emergency, contact:

Name:_____ Phone:_____

Relationship:_____

Physician's Name:_____ Physician Phone:_____

Medical Facility:_____ Facility Phone:_____

Heath Insurance Company:_____ Policy #:_____

In an effort to provide the best care possible, please indicate below:

I am allergic to the following medications:_____

I have the following ongoing medical conditions (diabetes, seizures, etc):_____

_____ _____

Signature Participant/Volunteer/Guest/Staff (Parent / Guardian if under 18) Date

CHECK ONE OF THE OPTIONS BELOW TO INDICATE CONSENT OR NON-CONSENT FOR EMERGENCY MEDICAL TREATMENT

CONSENT FOR EMERGENCY MEDICAL TREATMENT

☐ **I DO** consent for emergency medical treatment in the event emergency medical aid/treatment is required due to illness or injury while being on the premises of or in connection with Dream Catchers.

I authorize Dream Catchers and/or its representatives to:

1. Obtain medical treatment and/or transportation if needed:
2. Release records upon request to the authorized agency or its representative involved in the medial emergency treatment.

NON-CONSENT FOR EMERGENCY MEDICAL TREATMENT

☐ **I DO NOT** give my consent for emergency medical treatment in the case of illness or injury while on the premises of or in connection with Dream Catchers. In the event emergency medical aid/treatment is required due to illness or injury while being on the premises of or in connection with Dream Catchers I wish the following procedure to take place (***LIST PROCEDURE ON LINE BELOW):***

_____

Note: Dream Catchers is unable to guarantee that emergency medical treatment will be withheld

APPLICATION FOR EQUINE ASSISTED LEARNING (HOPE EAL Program-Adult Group)

Release, Waiver & Indemnity Agreement

I, the undersigned or parent or legal guardian of the undersigned (either as a "Participant, Volunteer, or Staff"), desiring to utilize the premises known as the Cori Sikich Therapeutic Riding Center and the adjoining properties known as 10128 Fire Tower Road and 10102 Fire Tower Road, and any adjoining property owned by Daniel Potter, Karen K. Potter, Neal E. Knemeyer, or NDK Investments, LLC, and Jennifer and Joshua Thibeault, and their heirs, for their properties located at 10046,10058,10070 Fire Tower Road, Toano, VA 23168 collectively known as "the Premises")and the facilities either owned or controlled by Dream Catchers at the Cori Sikich Therapeutic Riding Center ("DCTR"), and to participate in programs offered by DCTR (the Programs), do herby affirm that as a Participant, Volunteer, or Staff is voluntarily entering upon the Premises to participate in the Programs, and I, as the undersigned or parent or legal guardian of the undersigned, do herby willingly enter into this Release, Waiver and Indemnity Agreement.

I recognize that, under Virginia law, an equine activity sponsor or professional is not liable for an injury to or the death of a Participant, Volunteer, or Staff in equine activities resulting exclusively from the inherent risks of equine activities. I fully understand that the activity of mounting, riding, boarding, feeding, or even being near a horse, involves numerous dangers and risks of injury to the Participant, Volunteer, or Staff and I completely release the owner of the Premises, and DCTR and its officers, directors, volunteers, employees, or its agents from any and all liability for any and all injuries from the Participant's, Volunteer's, or Staff's engagement in the Programs offered by DCTR.

I expressly agree that this Release, Waiver, and Indemnity Agreement shall be governed and construed as being sufficient to satisfy the assumption of risk and waiver requirements necessary to relieve equine activity sponsors and equine professionals from liability under the Virginia Equine Activity Liability Act, Section 3.1-796.130, *et.seq*. of the Code of Virginia (the "Act"), and the owners of the Premises, DCTR and its officers, directors, volunteers, employees, and agents are covered as equine activity sponsors and/or equine professionals by the provisions of the Act. This Release, Waiver, and Indemnity Agreement shall be governed and construed by the laws of the Commonwealth of Virginia, regardless of where any injury or loss shall occur. In the event that any portion of this Release, Waiver, and Indemnity Agreement shall be declared unenforceable, such declaration shall not affect the remaining terms of this document, which shall survive intact.

I am also aware and consent to Participant's, Volunteer's, or Staff's inclusion in a study performed by DCTR that, in the interest of improving the quality and effectiveness of the programs offered, will gather data on the program participants. Such data will include, but not limited to, the age, gender, dates of participation, and level of satisfactions of the program participants. Program participants may be selected for the study at random, and DCTR affirms that all program participants not selected for the study will be treated in a manner substantially identical to those program participants. Data will be held strictly confidential and not published in any way or as part of any publication.

I hereby give my permission to participate in the Programs offered by DCTR as a Participant, Volunteer, or Staff, and in consideration, agree individually and as applicable, on behalf of my child or ward, to the terms of the above agreement and release of liability.

_____ _____

Printed Name of Applicant, Volunteer, or Staff Member Date

_____

Signature of Applicant, Volunteer, or Staff Member

_____

Signature of Parent or Guardian of Applicant, Staff or Volunteer if under the age of 18

APPLICATION FOR EQUINE ASSISTED LEARNING (HOPE EAL Program-Adult Group)

COVID-19 Assumption of Risk and Waiver of Liability

Coronavirus/COVID-19 Warning and Disclaimer

The novel coronavirus, COVID-19, has been declared a worldwide pandemic by the World Health Organization. COVID-19 is extremely contagious and is believed to spread mainly from person-to-person during close contact. Participating in or observing activities at Dream Catchers at the Cori Sikich Therapeutic Riding Center (the "Center") could increase your risk of contracting COVID-19, and **Dream Catchers cannot guarantee that you will not become infected with COVID-19.**

Acknowledgment of Risk

I, the undersigned, for myself and, if applicable, as parent/guardian on behalf of the minor named below, hereby acknowledge and agree that in consideration for the undersigned participating in or observing activities at the Center: (1) the undersigned is assuming the risks related to COVID-19 inherent to gathering with others and using common facilities and hereby waives the undersigned's rights to claim liability of Dream Catchers or others resulting from the assumption of such risks; and (2) Dream Catchers is not responsible for sickness or for loss of any kind as a result of COVID-19. I further understand that certain activities at the Center will require additional safety precautions and equipment due to COVID-19, and that, due to physical safety concerns and sudden emergent conditions, certain activities may not permit social distancing of 6 feet per person at all times.

Dream Catchers has taken certain steps to implement recommended guidance and protocols issued by the Centers for Disease Control and Prevention and the Virginia Department of Health for slowing the transmission of COVID-19. The undersigned acknowledges receipt of Dream Catchers' current policies and requirements for participation in or observation of activities at the Center in response to such guidance and protocols ("Dream Catchers' COVID-19 policies and requirements"). The undersigned acknowledges and agrees that Dream Catchers may revise its policies and requirements at any time based on updated recommended guidance and protocols issues by the public health agencies. **The undersigned agrees to comply at all times with Dream Catchers' COVID-19 policies and requirements.**

By signing this agreement, **I acknowledge the contagious nature of COVID-19 and voluntarily assume the risk that I may be exposed to or infected by COVID-19 while at the Center and that such exposure or infection may result in personal injury, illness, permanent disability, and/or death**. I understand that the risk of becoming exposed or infected by COVID-19 at the Center may result from the actions, omissions, or negligence of myself or of others, including Dream Catchers. I hereby forever release, waive, discharge, and hold harmless, and agree not to sue or assert any claim against, Dream Catchers (including its directors, staff, employees, volunteers, and agents) for any loss or damages arising from such exposure or infection. I understand that by signing this document, all liability of Dream Catchers (including its directors, staff, employees, volunteers, and agents) to myself for any such loss or damages will be forever extinguished. I, the undersigned, have read, understand and accept the terms of this Assumption of Risk and Waiver of Liability form. I further acknowledge that no oral representations have been made to me as an inducement to sign this form.

_____ _____

Printed Name of Participant, Volunteer, Guest, or Staff Date

_____

Signature of Participant, Volunteer, Guest, or Staff

_____

Signature of Parent or Guardian of Participant, Staff, Guest, or Volunteer if under the age of 18

APPLICATION FOR EQUINE ASSISTED LEARNING (HOPE EAL Program-Adult Group)
Financial Policies

(Please Keep A Copy Of This Page For Your Records)

- All fees from prior sessions must be paid in full, including late fees, before registering for the next session.
- The fee for each session must be paid in full during that session.
- The first payment is due the first week of each session. The 2nd and 3rd payments are due by the 10th of the following two months in that session.
- There is a $25 late fee for payments not received by their due date.
- There is a $25 late fee for registration forms returned later than the registration deadline.
- There is a $50 returned check fee for any check returned by our bank for insufficient funds.
- *There are no makeup lessons or refunds* for lessons cancelled due to severe weather.
- There are no makeup lessons for missed lessons.
- Services will not be provided to participants who are more than 15 minutes late for their service time.
- We will be relying on email as our primary method of communication.
- Please print all Dream Catchers documents emailed to you for your records and reference. They are your "official" notices.
- Please call the **CANCELLATION HOTLINE at 757-810-8826** as early as possible when you or your participant are running late or unable to attend a lesson. (Please notify the programs office about any planned abscesses). Please DO NOT CALL 757-566-1775 about late or missed lessons!

I have read and understand the financial policies: _____
Signature Date

APPLICATION FOR EQUINE ASSISTED LEARNING (HOPE EAL Program-Adult Group)

Registration & Payment Agreement

Registration Instructions:

- ***Please check all sessions in which the applicant may participate.***
- ***Selecting a session does not obligate you to participate, however it does help us with planning and registration. We will always confirm that you are participating in a selected session prior to charging your account.***
- ***If you are registering as a new participant your lesson day and time will be assigned following your initial assessment.***

Applicant Name:_____

Address:_____

City:_____ State:_____ Zip:_____

Home #:_____ Cell #:_____ Work #:_____

Email:_____

This group will run weekly on Tuesday mornings from 10 am to 11:30 am. I would like to register for the following sessions (you may select more than one):

Check the session you are interested in	Session	Dates	Cost	Registration Deadline
	1	2/2/21 through 3/23/21 (8 weeks)	$480.00	1/29/21
	2	3/30/21 through 5/18/21 (8 weeks)	$480.00	3/22/21

Please indicate your payment preference: ☐ I will pay the tuition in one lump sum ☐ I will pay the tuition in 3 payments

Please make a payment selection:

I/We choose to pay in the following way:

☐ By check (Please place in the grey metal lock box in the barn aisle or drop off at the Office Building)

☐ By bank auto draft (Please ask for an auto draft form if you are selecting this option)

☐ By Credit Card (Please complete the information below)

☐ VISA ☐ MC ☐ AMEX ☐ DISCOVER Card Number:_____

Name on Card: _____

Expiration:_____ **Security Code:**_____ **Billing Zip Code:**_____

I/we hereby authorize Dream Catchers to charge the payments that correspond with the payment plan selected for each session for which the participant is enrolled. This agreement is valid ONLY for the sessions checked above. The first payment will be charged the first week of each session with the remaining payments made on the 10th of the 2nd and 3rd month of the session. ***No fees will be charged if the applicant elects not to participate in sessions checked.***

Authorized Signature: _____ Date: _____