SADDLE POWER

An 8-week Core Conditioning and Strength Training Program on Horseback

Offering a full-body workout with an emphasis on core strength in a safe, controlled environment.

No horse or riding experience necessary! This class will take place on our beautiful 22-acre farm and you will be partnered with one of our well trained horses. Exercises will take place both on and off the horse and our dedicated team of volunteers will be assisting the instructor to ensure your safety
and comfort levels.

The walking motion of a horse engages the core muscles (abdominals and back) of the rider helping to:

Improve and increase balance
Improve coordination
Improve posture
Increase flexibility

Saddle Power will focus on:

Core Strength
Upper and lower body strength
Stretching and flexibility

Saddle Power also provides:

Stress relief
Relaxation
The opportunity to form relationships with both the horse and other participants

About the instructor: Janet Mayberry is a PATH Intl. Certified Therapeutic Riding Instructor with years of horse experience. She also has a background in personal fitness training.

Spring Series:

Tuesdays from 10 am to 11:30 am

April 27, 2021, May 4, 2021, May 25, 2021, June 1, 2021, June 8, 2021, June 15, 2021, June 22, 2021, and June 29, 2021

Saturdays from 1 pm to 2:30 pm

April 17, 2021, April 24, 2021, May 1, 2021, May 29, 2021, June 5, 2021, June 12, 2021, June 19, 2021, and June 26, 2021

8-week package for $325.00
Class size is limited to 5 participants

APPLICANT INFORMATION

Applicant Name: ____ Date: __________________________

Address: ____

City: ______________________________________ State: ___________ Zip Code: ________________

Phone: (H) _____________________ (W) _____________________ (C) _____________________

Email Address: ____

How did you hear about our saddle power classes? ____

____

Please share any additional scheduling preferences or restrictions you may have: ____________________

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Please list current/past experience with horses: ____

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Please share some specific goals that you would like accomplish: _____________________________

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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.

____ ______________________

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

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.

____ ______________________

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

MEDICAL HISTORY

Please complete the medical history information so that we can ensure your safety while participating in our services. This information will be kept confidential.

Applicant Name: ______________________________ Date: ______________

Address: ____

City: ______________________ State: __________ Zip Code: ____________

Height: __________ Weight: __________ Date of Birth: __________ Age: __________

<u>PLEASE LIST ALL CURRENT MEDICATIONS</u> (Additional medications can be listed on separate paper)

1. ______________________ Taken For ______________________

2. ______________________ Taken For ______________________

3. ______________________ Taken For ______________________

Do you have side effects from any of the medications listed above? ______________________

____

____

Please list any recent surgeries: ______________________

____

____

Are there any special precautions we need to know about? ______________________

____

Please answer the following medical questions:

Question	Answer
Do you have seizures?	□ YES □ NO
• Are seizures controlled?	□ YES □ NO
• Type of Seizure	
• Date of Last Seizure	
Do you have any indwelling medical devices?	□ YES □ NO
• Please list devices if applicable	

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

Check if applies	Condition	Note
	Allergies	
	Animal abuse	
	Atlantoaxial instability	
	Balance	
	Blood pressure control	
	Body temperature deregulation	
	Cancer	
	Cardiac	
	Chiari I or II malformation	
	Circulatory issues	
	Cognitive impairment	
	Coxa arthrosis	
	Cranial deficits	
	Eating disorder	
	Emotional/psychological	
	Fire setting	
	Hearing Impaired / Sensitivity	
	Hemophilia	
	Hydrocephalus	
	Hydromyelia	
	Immunity	
	Internal spinal stabilization device/s	
	Joint replacement	
	Joint subluxation/dislocation	
	Learning disability	
	Migraines	
	Muscular issues	
	Neurological condition	
	Orthopedic condition	
	Ossifications-Heterotopic	
	Ossificans-Myositis	
	Paralysis	
	Paralysis due to spinal cord injury	
	Pathological fractures	

Check if applies	Condition	Note
	Peripheral vascular disease	
	Physical/Sexual/Emotional abuse history	
	Pulmonary	
	Respiratory impairment	
	Self harm	
	Shunt/Shunt Revision	
	Skin break down	
	Speech impairment	
	Spina bifida	
	Spinal joint fusion / fixation	
	Spinal joint instability/abnormality	
	Stroke	
	Substance abuse	
	Tactile sensation impairment	
	Tethered cord	
	Thought control disorder	
	Visual impairment	

Please list any other medical conditions we should to know about:____

____

____

I understand that Dream Catchers will weigh this medical information against the existing precautions and contraindications. I hereby certify that the information I have provide is true and correct to the best of my knowledge and I hereby certify its accuracy.

Printed Name:____

Signature:____

Date:____

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):______________________________

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 medical 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**

____ ________________________

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

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, Guest, or Staff Date

____

Signature of Applicant, Volunteer, Guest, or Staff

____

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

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 Applicant, Volunteer, Guest, or Staff Date

____

Signature of Applicant, Volunteer, Guest, or Staff

____

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

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.
- Payments can be made in one lump sum or broken into a payment plan (3 payments) upon approval from the Operations Manager.
- 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

Payment Information

Payment is due in full with your completed application.

Please contact Beth Yurkovac, Operations Manager with any questions or special payment requests (757-794-3262).

Applicant Name:____

Please complete address information if different than information on Page 3:

Address:____

City:_______________________________________ State:______________ Zip:_______________

Home #:__________________ Cell #:__________________________ Work #:___________________

Email:____

Saddle Power Spring Series:

☐ Tuesday Class

☐ Saturday Class

<u>Please make a payment selection:</u>

I/We choose to pay in the following way:

☐ By cash

☐ By check (there is a payment lock box outside of the programs office in the barn)

☐ By Credit Card (Please complete the information below)

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

Name on Card: ____

Expiration:________________ **Security Code:**______________ **Billing Zip Code:**___________________

Authorized Signature: ____ Date: _____________________