

1/1/09

Dear Participant/Parent/Guardian:

Thank you for a wonderful year at Beyond Balance. To keep our records up to date, we are requiring all participants to fill out our registration forms regardless of when you last filled them out. These forms must be filled out every year to comply with our insurance and NARHA Standards.

We appreciate your understanding in filling out these forms.

<b>Registration Checklist</b>	<b>Yes</b>
Policies and Procedures	
Participant's Medical History and Physician's Release	
Participant Authorization for Emergency Medical Treatment	
Equine Activity and Hold Harmless Morning Mist Farm	

Thank you,  
Missy Rush  
Co-Executive Director

## Participant Information

Thank you for participating in our program. Please find the registration packet for our fall session. Complete the forms and then return them to Beyond Balance by September 7th. Beyond Balance is limited to providing service to individuals weighing 180 lbs. or less and who are at least 4 years old. We strive to make our classes a fun learning experience for all participants. The level of instruction is tailored to the participants' capabilities. There are many different programs offered at Beyond Balance, Inc., if the prospective client does not fall in the weight or age category, we may be able to tailor a horsemanship program to fit the client's needs.

Your safety and well being is our most important concern. Certain conditions require additional precautions to be taken when on or around horses and some conditions are contraindications to riding. Some conditions change throughout the year and a physician form is required yearly along with our release forms. Your physician must complete the Physician Release/Participant Medical History Form. Should the physical condition of the participant change at any time, Beyond Balance should be notified immediately and a new Physician Release Form must be completed.

The group lesson fee at Beyond Balance is \$30 for a ½ hour to 45 minute lesson depending on involvement of the participant. Private lessons may also be available depending on class schedules. This fee covers only a portion of the estimated operating cost for each participant. The remainder of the cost is covered by donations and fundraising. There are a limited number of riding scholarships available to participants in need of financial support. Please call our administrative office for further information.

Please fill out the contact information below and return with your registration packet.

Thank you for your continued support!

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### Contact Information

Participants Name: \_\_\_\_\_

Legal Guardians Name: \_\_\_\_\_

Phone Numbers where we can reach you if we need to talk about schedule or class changes: \_\_\_\_\_  
\_\_\_\_\_

Billing/Notification address: \_\_\_\_\_  
\_\_\_\_\_

Email: \_\_\_\_\_

## Participant Policies and Procedures

Listed below are policies and procedures for our participants. Some of our policies have changed, please read this form in its entirety then sign below and return it to the office.

### **Participant limitations**

**Beyond Balance** offers therapeutic horseback riding and provides service to adults and children 4 years and older. Due to the nature of the horses work, Beyond Balance has a weight limit of 180 lbs. or less for ambulatory persons. Weight limitations may differ for persons requiring a full transfer and will be at the discretion of the instructor. Certain conditions require additional precautions to be taken when on or around horses and **some conditions are contraindications to riding**. Horseback riding may not be a suitable recreational activity for certain individuals. Most activities have some type of precautions and contraindications for participation and horse riding is no exception. Behavioral issues that may cause harm to the animals, instructors, volunteers or place the participant in a dangerous situation cannot be tolerated, individuals who have spinal curvatures that are unable to accommodate the movement of the horse, or those who lack neck and trunk control to name a few may not be suitable participants.

Your physician will need to complete and sign the Physician Release/Participant Medical History Form. Should the physical condition of the participant change at any time, Beyond Balance should be notified immediately and a new Physician Release form must be completed. All participant forms will need to be updated on an annual basis.

### ***Clothing***

Participants should wear long pants such as riding breeches, jeans or leggings to prevent chafing of legs. Shoes or boots with a rounded toe and small heel are the safest form of footwear. Participants should avoid wearing jewelry, especially long dangling earrings. Safety helmets that meet ASTM-SEI requirements are required to be worn by all participants and will be provided for you.

### ***Inclement weather***

Please do not assume that classes will be cancelled due to bad weather. For some participants, it may mean that a stable management/horse care class will take place in the barn. If classes are cancelled a recorded announcement will be left on the Beyond Balance answer machine. If you hear the message on the machine, please leave your name to confirm you have heard the recording. We will also do our best to notify the participant of any changes or cancellations due to weather.

### ***Cancellation Policy***

It is difficult to re-schedule both horses and volunteers at short notice. If you know in advance that you have prior commitments and will be unable to attend a class, please advise us as soon as possible by calling the office at 609.969.8899. Participants who "no-show" and cancellations within 24hrs of the scheduled lesson time will forfeit the lesson cost. Three "no-shows" or late cancellations in a session will result in dismissal from the session and the participant will be put on the waiting list.

### ***Make-up policy***

Make-up classes will only be offered if there is an appropriate class time, horse and instructor available. There will be no make-ups offered for "no-shows" and late cancellations. Beyond Balance reserves the right to reschedule, cancel and amend classes and the operating calendar at any time.

### ***Payment Policy***

All participant fees must be prepaid you will be invoiced in advance for the upcoming session. We request that the cost of the entire session is paid in full prior to attending the first class. Alternative payment options may be available. If your balance becomes 30 days past due the participant will be unable to participate until balance is paid or other arrangements have been made. Please do not give your payments directly to the instructor; mail your check to: P.O Box 534 Hainesport, NJ 08036-0534.

There are a limited number of scholarships available to participants in need of financial support. Please contact the office for further information.

### **Ways to Help**

Parents are always encouraged to offer their support by volunteering during the participant's lesson time. There are many ways to help, if interested please contact the office.

**Yes, I am interested in volunteering**

### ***Safety Rules***

- Participants that display behaviors that are abusive and/or disruptive in manner to other participants, horses, staff or volunteers will not be allowed to participate for the safety of everyone involved.
- Please do not hand feed the horses.
- In order to comply with NARHA standards only participants and volunteers will be allowed in the barn area during classes. Parents and other spectators are asked to wait in the parent viewing area until students are finished with their class. For the safety of our participants please stay off of the mounting ramps and out of mounting ramp area.
- No dogs are allowed on property
- Participants must wear close-toed shoes. If a participant arrives wearing inappropriate shoes he/she will not be able to participate.

We strive to make this a fun, safe experience for everyone. Please do not hesitate to call the office with any questions you may have.

By signing below I agree that I have read and understand the above written policies and procedures.

Participant Name: \_\_\_\_\_  
*Please Print*

Signature: \_\_\_\_\_ Date \_\_\_\_\_  
*Participant, Parent or Legal Guardian*

*Additional copies of policies and procedures will be available on request.*

**Participant's Medical History and Physician's Release – Must be completed by Physician**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

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

Name of Parent / Guardian: \_\_\_\_\_

Diagnosis: \_\_\_\_\_ Date of Onset: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Tetanus shot: Yes: \_\_\_\_\_ No: \_\_\_\_\_

Seizure Type: \_\_\_\_\_ Controlled: \_\_\_\_\_ Date of last seizure: \_\_\_\_\_

Medications: \_\_\_\_\_

\_\_\_\_\_

Any contagious diseases: \_\_\_\_\_

**Please indicate if a patient has a problem and/or surgeries in any of the following areas. If yes, please comment, using the back of the form if necessary.**

Areas	Yes	No	Comments
Auditory			
Visual			
Speech			
Cardiac			
Circulatory			
Pulmonary			
Neurological			
Muscular			
Orthopedic			
Allergies			
Learning Disabilities			
Mental Impairment			
Psychological Impairment			
Incontinence			
Coordination			
Balance			

Mobility: Independent Ambulation: Yes \_\_\_\_\_ No \_\_\_\_\_ Crutches: Yes \_\_\_\_\_ No \_\_\_\_\_  
 Wheelchair: Yes \_\_\_\_\_ No \_\_\_\_\_ Braces: Yes \_\_\_\_\_ No \_\_\_\_\_

Please indicate any special precautions:

Physician's signature required on other side

**Physician Information**

The following conditions, if present, may represent precautions and contraindications to therapeutic horse riding. Please be sure to clearly identify if any of the following conditions are present and to what degree.

<b><u>Orthopedic</u></b>	<b>Yes</b>	<b>No</b>	<b><u>Medical/ Surgical</u></b>	<b>Yes</b>	<b>No</b>
Spinal Fusion			Allergies		
Spinal Instabilities/ Abnormalities			Cancer		
Atlantoaxial Instabilities			Poor Endurance		
<b><u>Scoliosis</u></b>			Recent Surgery		
Kyphosis			Diabetes		
Lordosis			Peripheral Vascular Disease		
Hip Subluxation and Dislocation			Varicose Veins		
Osteoporosis			Hemophilia		
Pathologic Fractures			Hypertension		
Coxas Arthrosis			Serious Heart Condition		
Heterotopic Ossification			Stroke (Cerebrovascular Accident)		
Osteogenesis Imperfecta			<b><u>Muscular</u></b>		
Cranial Deficits			<b><u>Hypotonic</u></b>		
Spinal Orthoses			Hypertonic		
Internal Spinal Stabilization Devices			Trunk Control, Upper/Lower extremity, please specify		
<b><u>Fractures</u></b>			<b><u>Neurologic</u></b>		
			Seizure disorders		
<b><u>Secondary Concerns</u></b>			Hydrocephalus/shunt		
Behavior problems			Spina Bifida		
Age under two years			Tethered Cord		
Age two - four years			Chiari II Malformation		
Acute exacerbation of chronic disorder			Hydromyelia		
Indwelling catheter			Paralysis due to Spinal Cord injury		

\*\*If student has Down Syndrome, an additional Atlantoaxial Dislocation X-ray form is required.\*\*

If yes was checked for Scoliosis, Kyphosis, Lordosis, Please List the Degree and the date of last X-Ray Below

**Scoliosis: Degree** \_\_\_\_\_ **Last X-Ray Date** \_\_\_\_\_

Kyphosis: Degree \_\_\_\_\_ Last X-Ray Date \_\_\_\_\_

Lordosis: Degree \_\_\_\_\_ Last X-Ray Date \_\_\_\_\_

Physician Verification – Please PRINT your name, sign & date – THANK YOU

**In my opinion there is no reason why this person cannot participate in supervised equestrian activities.**

Participant's Name: \_\_\_\_\_

Physician's Printed Name: \_\_\_\_\_

Physician's Signature: \_\_\_\_\_

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

Phone: \_\_\_\_\_

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

Further comments / Notes: \_\_\_\_\_

## Participant Authorization for Emergency Medical Treatment

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 Beyond Balance to: Secure and retain medical treatment and transportation, if needed Release client records upon request to the authorized individual or agency involved in the emergency medical treatment.

Participants Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ State/Zip: \_\_\_\_\_

In an emergency, Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

Physicians Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Preferred Medical Facility: \_\_\_\_\_

Health Insurance Co: \_\_\_\_\_ Policy #: \_\_\_\_\_

### **Please check one option listed below:**

**I give 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. 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 below is unable to be reached.

**I do not give 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:

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I \_\_\_\_\_ acknowledge the risks and potential for injury that may occur with the activities of horseback riding and working around horses, and I have discussed these risks with my child/and his/her/my physician. However, I feel that the possible benefits to myself/son/daughter/ward are greater than the risk assumed. Therefore agree to be legally bound for myself (or for my son/daughter/ward) and hold Beyond Balance, its Board of Directors, Instructors, Therapists, Aids, Volunteers, Employees and Morning Mist Farm, Property owner its employees, supervisors and associates harmless of any claim for damages, loss, or injury while at the Beyond Balance facility located on 1148 Smithville Rd Mount Holly N.J, or while off the property in conjunction with a Beyond Balance event. "WARNING UNDER NEW JERSEY LAW, AN EQUESTRIAN AREA OPERATOR IS NOTLIABLE FOR AN INJURY TO OR THE DEATH OF A PARTICIPANT IN EQUINE ANIMAL ACTIVITIES RESULTING FROM THE INHERENT RISKS OF EQUINE ANIMAL ACTIVITIES, PURSUANT TO P.L.1997, c. 287 (C.5:15-1 et seq.)"

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
*Participant, Parent or Guardian (if under 18)*

Print Name: \_\_\_\_\_ Phone: \_\_\_\_\_

