



Shining Stars Student Registration Form

3185 York Road - Gettysburg, PA 17325 - Email brandy@freedomvalley.org - (717) 398-8327

2010

- New Student**
- Returning Therapeutic Riding Student.** List Last Student Instructor _____
 Side Walkers Needed. Semi-Independent - Some Assistance. Independent - No Assistance.
- New Equine Assisted Learning Student (EAL)** **Returning EAL Student**

- Therapeutic Riding (TR)** 1/2 hour weekly class. Choice of weekday - 6:00 PM, 6:45 PM, 7:30 PM for 15 weeks May-September. Individual attention with instructor, horse leader- two side walkers for riders or other equine activities, maintenance, grooming, leading etc. Class fee is \$15.00. Benefits in physical, social, emotional and intellectual abilities.
- Independent & Semi Independent** Same schedules as therapeutic riding in a group setting with goals of equine skill level improvement and with therapeutic aspects presented.
- Equine Assisted Learning (EAL)** 1 hour, non-riding class on Wednesday for 8 weeks (May-July) 5:30 PM-6:30 PM or 6:45-7:45 PM. For kids going into 4th, 5th and 6th Grade. Enrollment is limited. Class fee is \$30.00. Small group work for boosting character skills.
- Not Sure**

<p>Student Name _____ Address _____ _____ City _____ State _____ ZIP _____ Telephone _____</p> <p>School Name _____ Grade _____ Teacher _____ Telephone _____</p> <p>Is the Student's behavior age appropriate most of the time? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Most of the Time. If Not, at what level? _____</p> <p>Sex _____ Height _____ Weight _____ Date of Birth _____</p> <p>Student Diagnosis/Disability _____ Assistive Devices <input type="checkbox"/> Wheelchair <input type="checkbox"/> Braces <input type="checkbox"/> Crutches <input type="checkbox"/> Other-Specify _____ List all Medications _____ _____ _____</p> <p>Is the student allergic to any medications? <input type="checkbox"/> No <input type="checkbox"/> Yes - If Yes, List all Medications _____ _____ _____</p> <p>Are their any side-effects our staff should know about? _____ _____ _____</p> <p>Should any medications be taken by the student, either regularly or in an emergency, while he/she is with us? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes - Explain _____ _____ _____</p>	<p>Seizures Is the student subject to seizures? <input type="checkbox"/> No <input type="checkbox"/> Yes- If Yes, How often _____ How long does it last? _____ Describe a usual seizure, action taken during & after seizure. _____ _____ _____</p> <p>Vision <input type="checkbox"/> Normal <input type="checkbox"/> Normal with Glasses <input type="checkbox"/> Problems <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Both <input type="checkbox"/> Close Up <input type="checkbox"/> Distance <input type="checkbox"/> Minimal Vision <input type="checkbox"/> Totally Blind _____</p> <p>Walking <input type="checkbox"/> Normal <input type="checkbox"/> Has difficulty walking on: <input type="checkbox"/> Rough terrain <input type="checkbox"/> Difficulty with balance <input type="checkbox"/> Cannot bear weight on legs <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Both. Uses assistive devices _____</p> <p>Sitting Skills <input type="checkbox"/> Normal <input type="checkbox"/> Needs a chair with back support. <input type="checkbox"/> Can not maintain sitting balance without complete support. _____ _____</p> <p>Arm-Hand <input type="checkbox"/> Normal <input type="checkbox"/> Limited <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Both Degrees of control <input type="checkbox"/> Moderate <input type="checkbox"/> Minimal <input type="checkbox"/> Total Hand skills Can use <input type="checkbox"/> Scissors <input type="checkbox"/> Pencil <input type="checkbox"/> Can point _____</p> <p>Toileting Skills <input type="checkbox"/> Normal <input type="checkbox"/> Must be reminded <input type="checkbox"/> Needs Help <input type="checkbox"/> On/Off toilet <input type="checkbox"/> With clothing <input type="checkbox"/> Diapers <input type="checkbox"/> Special Help _____</p> <p>Hearing Skills <input type="checkbox"/> Normal. <input type="checkbox"/> Can hear well. <input type="checkbox"/> Hearing loss <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Both. <input type="checkbox"/> Has hearing aid in <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Both. <input type="checkbox"/> Can care for hearing aid without help. <input type="checkbox"/> Cannot hear at all. _____</p> <p>Speech/Communication <input type="checkbox"/> Normal <input type="checkbox"/> Understands written words. <input type="checkbox"/> Understands spoken words. <input type="checkbox"/> Often only the family understands. <input type="checkbox"/> Uses only a few words. <input type="checkbox"/> No speech, uses gestures. <input type="checkbox"/> Uses a language board. <input type="checkbox"/> Other _____</p>
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Parent Guardian Other _____
 Name _____
 Address _____

 City _____ State _____ ZIP _____
 Telephone _____ Cell _____
 email _____
 Signature _____ Date _____

Person to contact if parent/guardian cannot be reached.
 Name _____
 Address _____

 City _____ State _____ ZIP _____
 Telephone _____ Cell _____

Shining Stars Therapeutic Riding

Freedom Valley Worship Center
3184 York Road
Gettysburg, PA 17325

Brandy Crago, Program Director
(717) 398-8327

Medical Release Form

TO BE COMPLETED BY HEALTH CARE PROVIDER (PHYSICIAN/NURSE)

Patient/Child's Name _____

Parent/Caregiver _____

Address _____

City _____ State _____ Zip _____

Height Ft. _____ In. _____ Current Weight _____

What is this patient/child's primary diagnosis? _____

Date of diagnosis _____

Is this patient/child currently receiving treatment? No Yes If yes, please explain _____

Does this patient/child have any other medical problems? _____

Does this patient/child have the need for braces, wheelchair or other mobility issues? _____

Does this patient/child have any rods, pins or other medical devices in place? _____

Does this patient/child have any type of seizure activity? _____

Controlled? No Yes Date of last seizure: _____

Special Precautions/Needs _____

Physician's Statement: I have examined _____
and find there is no reason why this person cannot participate in supervised equestrian activities.

Please Stamp or Print Clearly Office Mailing Address:

Office _____

Address _____

City, State Zip _____

Clinic / Day Phone _____ Emergency / On Call Phone _____

Signature of provider _____ Date _____

Print Name _____

Release and Waiver of Liability

In consideration of being permitted to participate in the equestrian activities being offered by Shining Stars/Freedom Valley Worship Center, the undersigned, for himself, his personal representatives, heirs, and next of kin, hereby agrees to the following:

1. Hereby, releases, waives, discharges and covenants not to sue Shining Stars/Freedom Valley Worship Center, its officers, employees, volunteers, and other participants all for the purposes herein referred to as "release", from all liability to the undersigned, his personal representatives, assigns, heirs and next of kin for any and all loss or damage, and any claim or demands therefore on account of injury to the person or property resulting in death of the undersigned, whether caused by the negligence of the release or otherwise while the undersigned is in or upon the premises for the purpose of participating in the Shining Stars/Freedom Valley Worship Center activities
2. Hereby agrees to indemnify and save and hold harmless the release and each of them from any loss, liability, damage, or cost they may incur due to the presence of the undersigned in or upon the premises and whether caused by the negligence or the release or otherwise.
3. Hereby assumes full responsibility for and risk of bodily injury, death or property due to the negligence of release or otherwise while on the premises.

The undersigned expressly acknowledges and agrees that the program activities can be very dangerous and may involve the risk of serious injury and/or death. The undersigned agrees that the foregoing release, waiver, and indemnity agreement is intended to be as broad and inclusive as is permitted by the law of the state in which the class is conducted and that if any portion thereof is held invalid, it is agreed that the balance shall, notwithstanding, continue in full legal force and effect.

The undersigned has read and voluntarily signs the release and waiver of liability and indemnity agreement, and further agrees that no oral representations, statements or inducements apart from the foregoing written agreements have been made.

I have read the release and agree to its terms:

Student

Student Signature

Date

Student Printed Name

Parent/Guardian if student is a minor

Date

Please review all questions and complete as much information as you can. Sign and date application where indicated. Enclose all four pages, include the \$15.00 application fee and return to Brandy Crago.