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THERAPEUTIC RIDING CENTER

SIMPLE CHANGES, INC.
TERMS AND CONDITIONS FOR HIPPOTHERAPY

I, _____(must be over 18) (the "Undersigned"), desires that _____ (the "Rider") receive Hippotherapy ("Treatment") at Simple Changes, Inc. ("Simple Changes") and [agrees to be bound/agrees to ensure that the Rider is bound] by the terms and conditions set forth herein.

ARTICLE I. MEDICAL INFORMATION.

A. The Undersigned certifies that the medical history form provided to Simple Changes as part of Rider paperwork (the "Medical History Form") is the complete and current medical history of the Rider.

ARTICLE II. ATTIRE.

The Undersigned [agrees to/agrees to ensure that the Rider] wears proper attire for riding lessons, including long pants, shoes (boots with at least a half inch heel is recommended), and an SEI-ASTM approved riding helmet with an attached harness that fits properly. The Rider must wear his/her approved riding helmet at all times when in the ring, during Lessons, in the barn, or otherwise near horses.

ARTICLE III. DISCIPLINE AND DISMISSAL

A. Simple Changes will not tolerate any Rider or Parent/Guardian who (i) engages in disruptive conduct, (ii) exhibits behavioral problems that are unacceptable or unsafe, (iii) makes sexual comments or engages in sexual conduct, (iv) is disrespectful to instructors and/or volunteers, or (v) fails to follow Simple Changes' Policies set forth in Exhibit B hereto (the "Policies").

B. Simple Changes may remove a Rider from the Program if its parent/guardian, family, or guests engages in unruly or unsafe behavior as determined by the Program Director or Executive Director. Simple Changes is under no obligation to issue a refund.

C. Riding at Simple Changes is at the sole discretion of Simple Changes. If at any time the Simple Changes staff determines that hippotherapy at Simple Changes is not an appropriate activity for a Rider, Simple Changes may remove said Rider from the Program.

ARTICLE IV. MISCELLANEOUS.

A. The Undersigned has executed and returned to Simple Changes the Medical History Form as part of Rider paperwork.

B. The Undersigned has executed and returned to Simple Changes Exhibit A attached hereto (Virginia State Requirements).

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C. The Undersigned [agrees to abide by/ensure the Rider complies with] the Policies (Exhibit B).

Corliss Wallingford
Executive Director
Simple Changes.
PO Box 991 Lorton, VA 22199
703.402.3613 (office) 703.372.2625 (fax)
simplechanges@hotmail.com

ACCEPTED BY: Signature: _____ Date:_____

_____
[Print Name of Parent/Guardian]

Rider Name: _____

Address: _____

_____

_____

Revised: October 2020

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EXHIBIT A

VIRGINIA STATE REQUIREMENTS

I, [Insert Name of Rider if Rider is 18 years of age and legally capable of entering into a contract; otherwise Insert name of Parent/Guardian], desires that [Insert Name of Rider] receive horseback riding lessons from Simple Changes, Inc. and have reviewed the following:

A. Except as provided in § 3.1-796.133 of the Virginia Code, an equine activity sponsor, an equine professional, or any other person, which shall include a corporation, partnership, or limited liability company, shall not be liable for an injury to or death of a participant resulting from the intrinsic dangers of equine activities and, except as provided in § 3.1-796.133 of the Virginia Code, no participant nor any participant's parent, guardian, or representative shall have or make any claim against or recover from any equine activity sponsor, equine professional, or any other person for injury, loss, damage, or death of the participant resulting from any of the intrinsic dangers of equine activities.

B. Except as provided in § 3.1-796.133 of the Virginia Code, no participant or parent or guardian of a participant who has knowingly executed a waiver of his rights to sue or agrees to assume all risks specifically enumerated under this subsection may maintain an action against or recover from an equine activity sponsor or an equine professional for an injury to or the death of a participant engaged in an equine activity. The waiver shall give notice to the participant of the intrinsic dangers of equine activities. The waiver shall remain valid unless expressly revoked in writing by the participant or parent or guardian of a minor.

C. I am aware of the inherent risks of horseback riding.

ACCEPTED BY:

Signature: _____ Date:_____

_____
[Print Name of Parent/Guardian]

Rider Name: _____

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EXHIBIT B

SIMPLE CHANGES POLICIES LORTON LOCATION

General Conduct Policy For Parents, Riders, And Guests During Lesson Time:

Prior to Lesson

- Please enter barn parking area slowly and watch for pedestrians and horses.
- Please do not open closed gates unless given permission.
- Park only in the designated parking area.
- If previous lesson is in progress or riders are dismounting, please stay in car or quietly go to parent/ rider waiting area.
- All riders are to wait at designated parent/rider waiting area until a volunteer or instructor comes to escort them to the barn or rider holding area. All other areas are off limits. *Please do not enter barn without permission from the instructor!*
- Any parent or guardian who leaves the premises during a lesson must leave a contact number with the riding instructor in case of emergency.

During Lesson

- While a riding lesson is in progress, all parents, family members, and guests must stay in waiting area or in their vehicles. All children MUST remain with and close to a parent or guardian at all times. The barn yard and adjacent areas are closed to the general public.
- No one may enter the fenced area unless requested by an instructor or volunteer.
- No loud noises (clapping, door slamming on cars, loud talking/ laughing, calling to riders, etc.) shall be permitted.
- No umbrellas, ball playing, bike riding or fast type movement games are allowed at any time.

After Lesson

- After lesson, as applicable, the riders will be returned to their parent, guardian or other transportation.

General Rules:

- All riders must wear a helmet when on or around the horses.
- All gates and stall doors shall remain closed. Do NOT enter the barn if the barn doors are closed - loose horses may be in the aisle ways. Please wait outside until doors are open.

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- Please enter barn or ring only at indicated areas. Do not wander around and pet horses in stalls or paddocks. All fencing is electric. You will get shocked if you touch it, so do not touch!
- There is no climbing, sitting, or standing on stall doors, fences, or gates including the ring.
- Smoking and consumption of alcohol beverages or drugs is prohibited on the premises.
- Do not approach a horse with a stroller or wheelchair unless the handler or rider tells you it is ok to do so. Horses may spook at the equipment.
- There are no personal dogs permitted at the property.
- There is no running around horses or riding areas.
- All trash is to be disposed of in trash barrels.
- No horses are to be handled without program staff's permission and/or supervision.
- Please respect others when speaking or socializing.
- Please do not pet any horse without permission. Do not feed treats to any horses in stalls or over the fence!

Riding at Simple Changes is at the sole discretion of Simple Changes. If at any time staff determines that hippotherapy at Simple Changes is not an appropriate activity for a Rider, Simple Changes may remove said Rider from the Program.

ACCEPTED BY:

Signature: _____ Date:_____

_____
[Print Name of Parent/Guardian]

Rider Name: _____

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Participant Application/ Photo Release/Liability Release

Mail To:
Simple Changes
P.O. Box 991
Lorton, VA 22199

GENERAL INFORMATION

Participant Name:_____DOB:_____

Weight:____Height:_____Age:___Gender: M F Home #_____Cell #_____

Address:_____City:_____State:_____Zip: _____

E-mail Address_____

Participant's Diagnoses/Date of Onset:_____

1. Parent/Guardian's Name:_____Relation:_____

Employer/ Job Title:_____Work #: _____

2. Parent/Guardian's Name:_____Relation:_____

Employer/Job Title:_____Work #: _____

Caregiver:_____Phone:_____

Address (if different than above)_____

PHOTO RELEASE

I ☐ **DO** ☐ **DO NOT** consent to and authorize the use and reproduction by Simple Changes, Inc. of any and all photographs and any other audio/visual materials taken of me/ my son/ my daughter/ my ward/my guests for promotional material, educational activities, exhibitions or for any other use for the benefit of Simple Changes, Inc., the Therapeutic Riding Association of Virginia, Simple Changes Farm, LLC, and/or Professional Association of Therapeutic Horsemanship, International.

Signature: _____ **Date**:_____
Participant (if over 18), Parent or Legal Guardian

Subsequent Year Initials:_____ Date: _____ Subsequent Year Initials:_____ Date _____
Participant (if over 18), Parent or Legal Guardian — Participant (if over 18), Parent or Legal Guardian

RELEASE OF LIABILITY

Participant's Name _____ would like to take part in activities at Simple Changes, Inc. I acknowledge the risks and potential for risks of horseback riding and related activities. However, I feel that the possible benefits to me/ my son/ my daughter/ my ward/my guests are greater than the risk assumed. I hereby, intend to be legally bound for myself/ my heirs and assigns, executors or administrators, waive and release forever all claims for damages against Simple Changes, Inc., its Board of Directors, Instructors, Therapists, Aides, Volunteers, Employees, Contributors, Horse Owners, and/or Simple Changes Farm, LLC, for any and all Injuries and/or losses I/ my son/ my daughter/ my ward/my guests may sustain while participating in activities at Simple Changes, Inc.

Signature:_____ **Date**: _____
Participant (if over 18), Parent or Legal Guardian

Subsequent Year Initials:_____ Date: _____ Subsequent Year Initials:_____Date: _____
Participant (if over 18), Parent or Legal Guardian — Participant (if over 18), Parent or Legal Guardian

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Participant Health History

Mail To:
Simple Changes
PO Box 991
Lorton, VA 22199

Participant Name_____

Please indicate current or past special needs in the following areas:

	Yes	No	Comments
Vision			
Hearing			
Sensation			
Communication			
Heart			
Breathing			
Digestion			
Elimination			
Circulation			
Emotional/Mental Health			
Behavioral			
Pain			
Bone/Joint			
Muscular			
Thinking/Cognition			
Allergies			

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

- **Medications** (include prescription, and over-the- counter) Attach additional sheet if needed.

  _____

- **Goals** (Why are you applying for participation? What would you or your child like to accomplish?)

  _____

  _____

- **Psycho/Social Function** (ie: Work/school including grade completed, leisure interests, relationships-family structure, support systems, companion animals, fears/concerns., etc.)

  _____

  _____

- **Physical Function** (ie: Mobility skills such as transfers, walking, wheelchair use, driving/bus riding)

  _____

  _____

Please make sure that the staff at Simple Changes is kept current on new progress/issues that arise with your participant's health. If your child has seizures please fill out the seizure information form completely.

Signature: _____ **Date**: _____
Participant (if over 18), Parent or Legal Guardian

Subsequent Year Initials: _____ Date: _____ Subsequent Year Initials: _____ Date: _____
Participant (if over 18), Parent or Legal Guardian Participant (if over 18), Parent or Legal Guardian

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Authorization for Emergency Medical Treatment

☐ Participant ☐ Staff

Mail To:
Simple Changes
PO Box 991
Lorton, VA 22199

Name: _____ DOB: _____ Phone: _____

Address: _____

Health Insurance Company: _____ Policy #:_____

Physician's Name: _____ Physician's Phone:_____

Allergies to medications: _____

Current medications: _____

In the event of an emergency, contact:

1. Name: _____ Relation: _____ Phone: _____

2. Name: _____ Relation: _____ Phone: _____

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 Simple Changes, Inc. to:

1. Secure and retain medical treatment and transportation if needed.
2. Release client records upon request to the authorized individual or agency involved in the medical emergency treatment.

☐ Consent Plan

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(s) above is unable to be reached.

Signature: _____ **Date**: _____
Participant (if over 18), Parent or Legal Guardian

Subsequent Year Initials: _____ Date: _____ Subsequent Year Initials: _____ Date: _____
Participant (if over 18), Parent or Legal Guardian Participant (if over 18), Parent or Legal Guardian

OR ☐ Non-Consent Plan

I do not give my 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.

- Parent or legal guardian will remain on site at all times during equine assisted activities
- In the event emergency treatment/aid is required, I wish the following procedure to take place:

_____

_____

Signature: _____ **Date**: _____
Participant (if over 18), Parent or Legal Guardian

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Mail To:
Simple Changes
PO Box 991
Lorton, VA 22199

Therapist Assessment

Does participant see a therapist (PT,OT, Speech, etc)? ☐ YES ☐ NO
If yes please have therapist fill out form and return

Participant's Name _____ Age _____

Diagnosis _____

School/Employeer_____

Does the Participant have behavior problems? Yes ____ No ____ Please Explain:_____

_____

Suggestions on how the behavior is best dealt with by the instructor:_____

_____

_____

What type of attitude does the Participant have towards him/herself and others? _____

_____

What are your Current Treatment Goals? _____

_____

Does the Participant exhibit any physical weakness? _____

_____

Can you suggest exercises that might help the Participant: _____

_____

Are there any precautions or restrictions the instructor should know about? _____

_____

Circle one: PT OT SLP

Therapist's Name _____ Phone _____

Address: _____City_____St_____Zip_____

Signature _____ **Date** _____

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SEIZURE INFORMATION FORM

Mail To:
Simple Changes
PO Box 991
Lorton, VA 22199

Does the participant have a seizure disorder? ☐ **YES** ☐ **NO**
If yes, please fill out this form about the seizure disorder. **If no, please sign bottom of form.**

Participant's Name: _____

1. What type of seizures does the participant have:

_____

2. What is the typical motor activity during a seizure:

_____

_____

3. What is the average duration of a seizure:

_____

4. How does then participant feel and behave after a seizure? How long does this last:

_____

_____

5. What should we do should a seizure occur while on a horse or at the center:

_____

_____

6. Is there anything else that we need to know about the seizure disorder:

_____

_____

By signing this form, you are agreeing to inform the Program Director and your riding instructor if there is a change in the frequency or type of seizure activity.

You must inform your instructor if the participant has had a seizure the day of a riding lesson. The Program Director reserves the right to not allow a participant to ride if they feel it is unsafe due to significant seizure activity or post-seizure weakness the day of a lesson.

Signature: _____ **Date**: _____
Participant (if over 18), Parent or Legal Guardian

Subsequent Year Initials: _____ Date: _____ Subsequent Year Initials: _____ Date: _____
Participant (if over 18), Parent or Legal Guardian Participant (if over 18), Parent or Legal Guardian

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PO Box 991 Lorton, VA 22199
703.402.3613 703.372.2625(fax)
simplechanges@hotmail.com
www.simplechanges.org

Date: _____

Dear Health Care Provider:

Your patient, _____, is interested in participating in supervised equine activities.
(participant's name)

In order to safely provide this service, our center requests that you complete/update the attached Physician Statement Form. Please note that the following conditions may suggest precautions and contraindications to equine activities. Therefore, when completing this form, please note whether these conditions are present, and to what degree.

Orthopedic
Atlantoaxial Instability - include neurologic symptoms
Coxa Arthrosis
Cranial Deficits
Heterotopic Ossification/Myositis Ossificans
Joint subluxation/dislocation
Spinal Joint Fusion/Fixation
Osteoporosis
Spinal Joint Instability/Abnormalities

Neurologic
Hydrocephalus/Shunt
Seizure
Spina Bifida/Chiari II malformation/
Tethered Cord/Hydromyelia

Other
Age - under 4 years
Indwelling Catheters/Medical Equipment
Medications - i.e. photosensitivity
Poor Endurance
Skin Breakdown

Medical/Psychological
Allergies
Animal Abuse
Cardiac Condition
Physical/Sexual/Emotional Abuse
Blood Pressure Control
Dangerous to self or others
Exacerbations of medical conditions
Fire Settings
Hemophilia
Medical Instability
Migraines
PVD
Respiratory Compromise
Recent Surgeries
Substance Abuse
Thought Control Disorders
Weight Control Disorder

Thank you very much for your assistance. If you have any questions or concerns regarding this patient's participation in equine assisted activities, please feel free to contact the center at the address/phone indicated above.

Sincerely,
Jenny Spain
Simple Changes
Program Director

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PO Box 991 Lorton, VA 22199
703.402.3613 703.372.2625(fax)
simplechanges@hotmail.com
www.simplechanges.org

Physician Statement

To be filled out by participant's doctor and completed annually.

Participant: _____ DOB: _____ Height: _____ Weight: _____
Address: _____
Diagnosis: _____ Date of Onset: _____
Past/Prospective Surgeries: _____
Medications: _____
Seizure Type: _____ Controlled: Y N Date of Last Seizure: _____
Shunt Present: Y N Date of last revision: _____
Special Precautions/Needs:_____
_____
Mobility: Independent Ambulation: Y N Assisted Ambulation: Y N Wheelchair: Y N
Braces/Assistive Devices: _____
For those with Down Syndrome: **AtlantoDens Interval X-rays, date: _____ Result:_____**
Neurologic Symptoms of AtlantoAxial Instability: _____

Please indicate current or past special needs in the following systems/areas, including surgeries:

	YES	**NO**	**If Yes Please Comment**
Auditory			
Visual			
Tactile Sensation			
Speech			
Circulatory			
Cardiac			
Integumentary/Skin			
Immunity			
Pulmonary			
Neurologic			
Muscular			
Balance			
Orthopedic			
Allergies			
Learning Disability			
Cognitive			
Emotional/Psychological			
Pain			
Other			

To my knowledge, there is no reason why this person cannot participate in supervised equine activities. However, I understand that Simple Changes staff/therapists will weigh the medical information above against the existing precautions and contraindications. I concur with a review of this person's abilities/limitations by a licensed /credentialed health professional (e.g. PT, OT, SLP, Psychologist, etc.) in the implementation of an effective equine activity program.
Name/Title (please print): _____ _____
Address: _____
Phone: ( )_____ License/UPIN Number: _____

Signature_____ Date_____

.

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Date: _____

Dear Health Care Provider:

Your patient, _____

(Participant's name)

has been participating in supervised equine activities at Simple Changes therapeutic riding center and is due for an update of their medical status. Please review their previous medical history and provide an update of the information in the space below. Address occurrences over the past year including surgeries, illnesses, hospitalizations, changes in medications, treatment, weight, or behavior. **Please indicate current height/weight**. If this person has Down syndrome or any other condition that predisposes him/her to Atlantoaxial Instability, please include results of his/her neurologic exam.

Diagnosis: _____

Height: _____ Weight: _____

Update Status: _____

_____

_____

_____

_____

_____

_____

_____

_____

Given the above diagnosis and medical information, this person is not medically precluded from participation in equine assisted activities and/or therapies. I understand that the PATH center will weigh the medical information given against the existing precautions and contraindications. Therefore, I refer this person to the PATH center for ongoing evaluation to determine eligibility for participation.

Name/Title: _____ MD DO NP PA Other _____

Signature: _____ Date: _____

Address: _____

Phone: (____) _____ License/UPIN Number: _____

Send completed form to: Simple Changes PO Box 991 Lorton, VA 22199 or fax 703.372.2625

703.402.3613 **www.simplechanges.org** **simplechanges@hotmail.com**