



Dear Parent,

Welcome to New Horizons Center for Equine Assisted Therapy! Enclosed, please find paperwork regarding your child's involvement in New Horizons' riding and driving programs. This set of forms will provide New Horizons with information and history, as well as permission for New Horizons to work with your child. This information will be kept confidential.

Some general considerations:

Remind your child to wear proper clothing and footwear – closed shoes or boots (with a heel), jeans or pants, and jacket if appropriate for the temperature - that can get dirty/dusty. Children should not wear loose jewelry (bracelets, earrings, etc) that could become caught. Sun block should be worn in the warmer seasons and it is a good idea to bring water to summer sessions. New Horizons is not responsible for any materials that your child may find or bring home from the barn, or any items left at the barn.

While at the barn, the participating staff bringing your child is responsible for your child at all times. Children who would like to bring family or friends to meet the horses may do so, but need to schedule a time with New Horizons so that a staff member can be present.

We look forward to working with you. Please let us know if we can provide any additional information.

Sincerely,

*Beth Stone*

Beth Stone  
New Horizons Center for Equine Assisted Therapy  
[www.ridenewhorizons.org](http://www.ridenewhorizons.org)  
(401) 397-9242 email- [ridenewhorizons@aol.com](mailto:ridenewhorizons@aol.com)  
86 Foster Center Road, Foster, RI 02825

*The cost of our programs is \$60.00 per weekly session. Financial aid may be available to those who qualify through:*

Shriners of Rhode Island Charities Trust  
1 Rhodes Place, Suite 1  
Cranston, RI 02905  
(401) 941-2110





**Medical History and Release**

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

Address \_\_\_\_\_

City, State, Zip \_\_\_\_\_

Phone (H) \_\_\_\_\_ (W) \_\_\_\_\_ (C) \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Tetanus Shot: Y[ ] N[ ]

Emergency Contact Name/Number: \_\_\_\_\_

Medications (*Please list names, routes, dosages, side effects. Please state whether the medication impacts balance, sensitivity to sunlight, etc*)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

*Please check any areas of medical concern. Please explain in the Comments section*

**Areas**

**Comments**

Auditory \_\_\_\_\_

Visual \_\_\_\_\_

Speech \_\_\_\_\_

Cardiac \_\_\_\_\_

Circulatory \_\_\_\_\_

Pulmonary \_\_\_\_\_

Neurological \_\_\_\_\_

Does your child have a seizure disorder? \_\_\_\_\_

Muscular \_\_\_\_\_

Orthopedic \_\_\_\_\_

Allergies / Asthma \_\_\_\_\_

Allergies to hay \_\_\_\_\_ bee stings \_\_\_\_\_ dust \_\_\_\_\_ mold \_\_\_\_\_

Does your child carry an epi pen? \_\_\_\_\_

Learning Challenges \_\_\_\_\_

Psychological Impairment \_\_\_\_\_

Diabetes \_\_\_\_\_

Other \_\_\_\_\_

**By signing this form, I, \_\_\_\_\_ (please print parent/guardian name) certify all information to be complete and true to the best of my knowledge.**

Parent/Guardian's Signature: \_\_\_\_\_

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

**Additional Comments or Concerns:**

## AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize: \_\_\_\_\_

to release information from the record of: \_\_\_\_\_

DOB: \_\_\_\_\_

The information is to be released to: New Horizons Center for Equine Assisted Therapy for the purpose of developing an equine assisted therapy or equine assisted learning program for the above named participant. The information to be released is indicated below.

- Medical History
- Physical Therapy evaluation, assessment and program plan
- Occupation Therapy evaluation, assessment and program plan
- Speech Therapy evaluation, assessment and program plan
- Mental Health diagnosis and treatment plan
- Individual Habilitation Plan (I.H.P.)
- Classroom Individual Education Plan (I.E.P.)
- Psychosocial evaluation, assessment and program plan
- Court or Probation documentation
- Other: \_\_\_\_\_

This release is valid for one year and can be revoked, in writing, at my request

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

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

Relation to Participant: \_\_\_\_\_

Please send materials to:

**New Horizons Center for Equine Assisted Therapy  
86B Foster Center Road  
Foster, RI 02825**



## Permission Slip

PHOTO RELEASE: I hereby consent to and authorize the use and reproduction by New Horizons Center for Equine Assisted Therapy of any and all photographs and any other audiovisual materials taken of me/my child/my ward for promotional printed material, educational activities, exhibitions, or for any other use for the benefit of the program.

### LIABILITY RELEASE:

I acknowledge the risks and potential risks of interacting with horses. However, I feel the possible benefits to my family or the child I care for are greater than the risk assumed. I hereby, intending to be legally bound for myself, my heirs and assigns, executors or administrators, waive and release forever all claims for damages against New Horizons Center for Equine Assisted Therapy, its board of directors, instructors, therapists, volunteers and/or Employees for any and all injuries and/or losses I may sustain as a result of use of New Horizons Center for Equine Assisted Therapy property, equipment, or facilities while participating.

EMERGENCY RELEASE: In the event emergency medical aid/treatment is required due to illness or injury while participating, I authorize New Horizons Center for Equine Assisted Therapy 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. This authorization includes x-rays, surgery, hospitalization, medication and any treatment deemed "life saving" by the physician. This provision will only be invoked if the parent/guardian or emergency contact person listed cannot be reached.

### WARNING -

*Under Rhode Island law, an equine professional is not liable for an injury to, or the death of, a participant in equine activities, pursuant to chapter 21 of Title 4 of the General Laws.*

***I have read the above releases, and permit my child to participate in the New Horizons Center for Equine Assisted Therapy programs. Further I give Photo, Liability, and Emergency Consent, as described above:***

**Child's Name** \_\_\_\_\_

**Signature** (parent / guardian) \_\_\_\_\_ **Date** \_\_\_/\_\_\_/\_\_\_

**Print Name** \_\_\_\_\_

