



Welcome to STAR Therapeutic Equestrian Center! We have over 20 years of experience enhancing quality of life for children and adults of all cognitive, physical, and social abilities.

Our minimum age is 6 years old to be considered for our riding program, and our maximum weight we can accommodate for horse safety reasons is 230 lbs.

STAR Therapeutic Equestrian Center operates on a year round schedule. We allow a week for make-up classes, if needed, and a horse break week when there are no classes.

Fees for lessons are dependent on session format (group, semi-private, or private) and commitment to an entire session vs the occasional lesson. Fees are listed on our enrollment packets reflecting the total for a 4-week session.

Application Process:

1. Read and understand enrollment packet Participant Program and Payment Guidelines.
2. Complete and submit entire enrollment packet. Packets are not considered complete until all forms are returned and signed correctly.
3. Each applicant will be individually screened for precautions and contraindications; further information may be requested by Center Director.
4. The applicant must be able to partially assist in their mounting and dismounting, balance and trunk control.
5. You will be contacted to schedule an initial assessment once your enrollment packet is reviewed by the Center Director. An assessment is not required for recreational riding.
6. After assessment is completed, Center Director will determine if EAAT is appropriate for the potential participant and if so, which program and lesson day/time best meets the participant's needs.
7. Once completed participants will be scheduled for the next session or lesson week via a phone call or email from our Office Manager.



Participant Application and Health History

<u>Star use only:</u>
Date received: _____
Given to finance: _____
Prepaid: Y N

Date: _____

General Information

Participant Name: _____

DOB: _____ Age: _____ Height: _____ Weight: _____ Gender _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email: _____

Parents/Guardians: _____

Emergency Contact: _____ **Phone:** _____

How did you hear about the program? _____

Please list best available days and times for scheduling (weekdays/ends, after school, etc) _____

While STAR cannot guarantee your exact preference, we do our best to work within your availability and scheduling availability for a lesson time. If we cannot get you in to a session based on scheduling availability – you will be waitlisted until next session.

Is participant registering through an agency: yes no Contact Person: _____

Agency Address: _____

Agency Phone: _____ Ext. _____

I am registering for the following class type:

Therapeutic Riding or Recreational Riding

_____ Private 1 Hour Lesson	\$280.00/4 weeks
_____ Semi-private 1 Hour Lesson	\$240.00/4 weeks
_____ Group 1 Hour Lesson	\$180.00/4weeks
_____ One Time ride for 1 Hour	\$75.00 per lesson
_____ Pay as Go Lessons	\$65 per lesson
_____ Ground	\$50 per lesson/ \$180 for 4 weeks
_____ 1/2 Hour Therapeutic	\$50 per lesson

Class length and fees are determined per program/individual for these programs

Program Payment Guidelines:

- Payment must be received on or before the first lesson of each session. If payment is not received on or before the first riding lesson, the rider will not participate in class and may forfeit the class spot.
- Current participants with a remaining balance are not eligible to register for the next session unless the balance is paid in full.
- **NO REFUNDS WILL BE GIVEN AFTER SESSION BEGINS**

Health History

Participant: _____ Date: _____

Diagnosis: _____ Date of onset: _____

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

	Y	N	
Vision			
Hearing			
Sensation			
Communication			
Heart			
Breathing			
Digestion Elimination			
Circulation			
Emotional/Mental Health			
Behavioral			
Pain			
Bone/Joint			
Muscular			
Thinking/Cognition			
Allergies			

Medications (include prescriptions and over-the-counter, name, dose and frequency)

Physical Function (e.g. mobility, skills such as transfers, walking, wheelchair use, driving/bus riding)

Psychosocial Function (e.g. work/social including grade completed, leisure interests, relationships-family structure, support systems, companion animals, fears/concerns, etc.)

Goals (i.e. why are you applying for participation? What would you like to accomplish?)

Signature: _____ **Date:** _____

Participant, Parent/Guardian (if under 18)

Star Community®, STAR Equestrian Center, 13674 Greencastle Pike, Hagerstown, MD 21740

Office: 301-791-6222 Fax: 301-791-0018 www.communityinc.org

Email: eqcenter@starcommunityinc.org



Participant Emergency Medical Treatment Form

In the event emergency medical aid and/or treatment is/are required due to illness or injury, I authorize Star Community® to:

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

Participant Name: _____ Phone: _____

Address: _____

Emergency Contact: _____ Phone: _____

Alternate Emergency Contact: _____ Phone: _____

Physician's Name: _____ Phone: _____

Preferred Medical Facility: _____

Health Insurance Co.: _____ Policy #: _____

Consent Plan

This authorization includes, but is not limited to, X-rays, surgery, hospitalization, medication and/or any treatment procedure deemed "lifesaving" by the physician. This provision will only be invoked if the person(s) listed above is/are unable to be reached.

Date: _____ **Signature:** _____
Parent or Guardian

Printed Name: _____ Phone: _____

Address: _____

Non-Consent Plan

I do not give my consent for emergency medical treatment/aid in the case of illness or injury. I expressly agree to indemnify and hold STAR Therapeutic Equestrian Center harmless against any and all claims, demands, damages, rights of action, or causes of action that may arise from injuries sustained as a result participating in STAR Therapeutic Equestrian Center activities. In the event emergency treatment/aid is required, I request the following procedures to take place:

Date: _____ **Signature:** _____
(Parent or Guardian)

Printed Name: _____ Phone: _____

Address: _____



Participant's Consent for Release of Information

I hereby authorize: _____
(person or facility)

To release information from the records of: _____
(participant's name)

The information is to be released to: _____
(center or therapist's name)

For the purpose of developing an equine activity program for the above named participant. The information to be released is indicated below:

- Medical history
- Physical therapy evaluation, assessment and program plan
- Speech therapy evaluation, assessment and program plan
- Mental health diagnosis and treatment plan
- Individual Habilitation Plan (IHP)
- Classroom Individual Educational Plan (IEP)
- Psychosocial evaluation, assessment and program plan
- Cognitive-behavioral management plan
- Other: _____

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

Signature: _____ **Date:** _____

Print Name: _____

Relationship to Participant: _____

Please send materials to:

Star Community®, STAR Equestrian Center, 13674 Greencastle Pike, Hagerstown, MD 21740
Office: 301-791-6222 Fax: 301-791-0018 www.starcommunityinc.org



Participant Liability Release

I understand and acknowledge that equine activities involve risk of serious injury, including permanent disability and death. However, I feel that the benefits to me are greater than the risks assumed. I hereby certify that I know of no medical problems so as to would increase my risk of illness or injury as a result of participation in any activity associated with STAR Therapeutic Equestrian Center.

In consideration of my participation in the STAR Therapeutic Equestrian Center programs and/or use of the facilities provided by STAR Therapeutic Equestrian Center, Star Community®, I expressly agree and contract, on behalf of myself, my heirs, executors, administrators, successors and assigns, that damages arising from personal injuries (including death) sustained by me in result, in whole or in part, from the negligence of STAR. By the execution of the agreement, I accept and assume full responsibility for any and all injuries, damages (both economic and non-economic), and losses of any type, which may occur to me and I hereby fully and forever release and discharge STAR Therapeutic Equestrian Center, its insurers, employees, officers, directors, and associates, from any and all claims, demands, damages, rights of action, or causes of action, present or future, whether the same be known or unknown, anticipated or unanticipated, resulting from or arising out of the participation in and /or use of said programs and facilities.

Signature: _____
Participant (if 18 and over) /Parent or Guardian

Date: _____

Printed Name: _____



Individual Photo Release Form

Name of Individual:	Permission Given (x)	Permission Denied (x)
Pictures of individual can be taken on Star-owned devices and provided to Star's nursing staff as deemed medically necessary.		
Pictures of individual can be taken on Star-owned devices and posted on Star Community's website		
Pictures of individual can be taken on Star-owned devices and posted on Star's Facebook Page and/or other social media pages		
Videos of the individual can be taken on Star-owned devices and posted on Star's social media pages.		
Pictures of the individual can be taken on Star-owned devices and used in Star's promotional print publications including, but not limited to Annual Reports, newsletters, appeal letters, brochures, display boards, training materials, etc.		
Pictures or videos can be taken on Star-owned devices or at a professional photo studio for personal usage of the individual such as being hung in the home, put in photo albums, or shared with family. This permission excludes other publication of the pictures and videos.		

Under this permission, I (the individual) retain the right to refuse being photographed or videoed on any occasion for any reason. Star will keep last names confidential unless permission is specifically granted on an as-requested basis.

Person's or Legal Guardian's signature:

Date:

This release will remain valid until written notification is provided to change the status of photo release.



Participant Physicians Statement

Filled out by the participant's
doctor.

Date: _____

Participant: _____ **Date of Birth:** _____ **Height:** _____ **Weight:** _____
Address: _____
Name of Parent/Guardian/Caregiver: _____
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: _____

Tetanus Shot: Yes No **Date:** _____

Mobility: *Independent Ambulation:* Yes No
Wheelchair: Yes No

Crutches or Braces: Yes No
Other: _____

For those with Down Syndrome:

Neurologic Symptoms of Atlantoaxial Instability: _____ **Present** _____ **Absent**

Negative Cervical X-ray for Atlantoaxial Instability. **X-ray Date:** _____

Please indicate current or past special needs in the following systems/areas, including surgeries. These conditions may suggest precautions and contraindications to equine activities.

AREAS	YES	NO	COMMENT
Auditory			
Visual			
Speech			
Cardiac			
Circulatory			
Pulmonary			
Neurological			
Muscular			
Orthopedic			
Allergies			
Learning Disability			
Mental Impairment			
Psychological Impairment			
Other			

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 Star Therapeutic Equestrian Center will weigh the medical information given against the existing precautions and contradictions. Therefore, I refer this person to Star Therapeutic Equestrian Center for ongoing evaluation to determine eligibility for participation.

Physician/Title: _____ **MD DO PA NP Other** _____

Signature: _____ **Date:** _____

Practice Address: _____

Phone: _____ **License/UPIN Number:** _____



Participant Program Guidelines

- Lessons are given on a year round basis. We allow a week for makeup lessons if necessary and the horses have a break for a week during which there will be no classes.
- New Therapeutic riders must complete a riding assessment prior to being scheduled in a class.
- Before registering for riding lessons, please be advised: Register for riding at a time when you can attend all scheduled classes. Regarding lessons missed due to sickness/injury/COVID, each rider is still expected to pay for those missed lesson(s). **(We do not offer make ups, unless there is a cancellation by the instructor)**
- Classes canceled by the instructor will be made up during the makeup week. Make-up classes may or may not be scheduled at the usual day/time.
- Classes that fall on major holidays: Easter, Memorial Day, Labor Day, Thanksgiving, Christmas will not be made up, riders will not be charged for these classes.
- Instructors, at their discretion, may plan non-mounted horsemanship classes in the case of horse illness, excessive rain, wind or temperature that make it unsafe to be mounted.
- Riding lesson content includes: safety, grooming, ground handling, tacking, correct body position while riding, harmony with the horse, and confidence building.
- If a participant is going to miss/cancel a lesson, please notify STAR before scheduled lesson via call or email. Classes that a participant calls out from are not made up.
- If a participant has 3 no call no shows during a session, they will forfeit participation for remainder of said session and jeopardize participation in future sessions. A no call no show is a failure to contact/report to the EQ prior to the start of the assigned lesson time via phone call/voicemail or email.
- For safety reasons we do not allow observers in the arena or stable area during classes. There are observation areas for parents/caregivers and family to watch. However, please let us know if you would like to take photos of your favorite rider in a lesson so the instructor can get your rider only set up for picture taking.
- For safety reasons, a parent/caregiver (who brings the participant) must be present on the property for the duration of the lesson.
- Please do not arrive more than 5 minutes before the start of class. Participants who arrive more than 15 minutes after scheduled class time will not be permitted to join the class and will not receive a makeup for that class.
- Every participant in every mounted class must wear properly fitting ASTM/SEI approved helmets. STAR provides approved helmets if participants don't have one. Participants must wear long pants that reach the ankle when riding and they must wear sturdy closed toed, closed heeled shoes or boots. Failure to follow pants/shoes consideration may result in forfeiting the lesson.
- Each participant must have an updated Participant Application/Contract, Participant Guidelines, Liability Release, Media Release, Authorization for Medical Treatment and Health History form on file in the office at all times when actively part of programs at STAR. Therapeutic riders must have an updated Physicians Statement and Consent for Release of Information on file at all times while actively part of programs at STAR.
- "Horse Play" will not be tolerated in the stable, arena, or observation area.
- Participants are only allowed to turn out horses after class if accompanied by a volunteer or instructor.
- Parents need to limit the time they talk to the instructor during regular class time. Feel free to call and schedule a time to talk if you have a question or concern.
- Participants are responsible to put their equipment away after their lesson.
- Positively no alcoholic beverages or drugs allowed on the property.
- Smoking is allowed only in the designated smoking area - on the other side of the lane from the parking lot.
- Dogs are not permitted on the Equestrian Center grounds except for certified service dogs.
- Program payment guidelines are explained under the prices in this packet.

I agree to abide by the above written guidelines – program and payment guidelines.

I understand and agree that these Participant Registration and Information Packet are valid for one (1) year. It is my responsibility to provide STAR with any changes or updates during this period. STAR will provide these forms on an annual basis. Failure to comply will result in temporary suspension of participation, without make up or refund until paperwork is made current.

Signature: _____

Date: _____