CARLISLE ACADEMY
INTEGRATIVE EQUINE
THERAPY & SPORTS

EQUINE ENRICHMENT FORMS

Welcome to Carlisle Academy! Below you will find all required registration paperwork as well as our enrollment process checklist to help you get started.

Registration Checklist: Please make sure that you complete **all** paperwork that applies to the program you are registering for.

- Emergency Medical Form
- Liability and Inherent Risks Form
- Participant Information Form
- Privacy Notice
- Equine Enrichment/Unmounted Medical Form

Please visit our website or e-catalog to peruse the various programs to determine best fit and eligibility. The following are the next steps that students must meet before we can enroll them in our program:

1. The first step is to contact the Head of School at Carlisle Academy to discuss space availability and program suitability (207-985-0374, info@carlisleacademymaine.com).

2. An intake and farm tour will be scheduled with the appropriate Carlisle to establish a suitable program. Carlisle staff will review all paperwork including scholarships through our charitable partner, the Carlisle Charitable Foundation if eligible.

3. Once the enrollment material is received, the student is enrolled in an upcoming session or placed on a waiting list.

Thank you for your interest in our program. We look forward to working with you!

Sarah Armentrout, Head of School

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STUDENT AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

NAME: _____ DOB: _____
ADDRESS: _____
EMAIL: _____Phone #1_____Phone #2_____

Physician's Name: _____ Preferred Medical Facility: _____
Primary Health Insurance#1: _____ Policy #: _____
Secondary Health Insurance #2: _____ Policy #:_____
Primary Care Physician: _____ Telephone #:_____ _____
Allergies to medication or other known allergies: _____
_____
Current medications/dosing/side effects:
_____
In the event of an emergency contact:
Name: _____ _____ Phone #1:_____ Phone#2:_____
Name: _____ _____ Phone #1:_____ Phone#2:_____
Name: _____ _____ Phone #1:_____ Phone#2:_____

Consent Plan
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 Spring Creek Farm, I authorize Carlisle Academy 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 emergency medical treatment.

This authorization includes x-ray, surgery, hospitalization, medication and any treatment procedure deemed lifesaving and medically necessary by the treating physician. This provision will only be invoked if the person (s) above is unable to be reached.

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 being on the property of Spring Creek Farm.

□ 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:

_____

□ I have advanced directives and a copy of this is with:

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Release of Liability

This **Release of Liability** is made and entered into this _____ day of _____, 20__, by and between Carlisle Academy Integrative Equine Therapy & Sports, LLC (hereinafter referred to as Provider), Nick & Sarah Armentrout (hereinafter referred to as Property Owner), Spring Creek Farm (hereinafter referred to as Host Facility), and Student _____ (hereinafter designated as Student, and if Student is a minor, Student's Legal Guardian).

Therefore, in consideration of the use, today and on all future dates, of the property, facilities and equipment of the Provider and Property Owner, their agents, successors, or assigns, the Student, his/her heirs, assigns, parents and legal representatives assume any and all risks involved in or arising from Student's use of Provider's services or presence on Property Owner's property or facilities.

The Student thereby waived and releases forever all claims for damages against instructors, therapists, apprentices, aides and/or employees, as well as the Property Owner and Host Facility and its family members, officers, employees, agents (including the insurance companies that insure both entities) and AGREES NOT TO SUE them on account of or in connection with any claims, causes of action, injuries, damages, costs or expenses Student may incur or sustain while receiving services from or on the premises of Spring Creek Farm.

Student agrees to abide by all of Provider's rules and regulations as they now exist or as they may be amended from time to time. In particular, Student agrees to wear properly fitted and secured ASTM/SEI certified protective equestrian headgear when riding horses as well as appropriate footgear if stirrups are used.

STATEMENT OF INHERENT RISKS

(Title 7 M.R.S.A. Sec. 4104A)

I, _____ (Student or Student's Legal Guardian, if a minor) acknowledge that I have read and fully understand the following statement of inherent risks, and that I am participating in equestrian therapies and/or sports despite the potential risks.

Equine activities involve a degree of risk that can result in injury or even death, including, but not limited to, the following:

a. The propensity of an equine to behave in ways that may result in injury, harm or death to persons on or around the equine;
b. The unpredictability of an equine's reaction to such things as sounds, movements and unfamiliar objects, persons or other animals;
c. Certain hazards, such as surface or subsurface conditions;
d. Collisions with other equines or objects; and
e. The potential of a participant to act in a negligent manner that may contribute to injury to the participant or others, such as failing to maintain control over the equine or not acting within the participant's ability.

Student/Legal Guardian: _____ Date: _____

Having read and signed the **Statement of Inherent Risks** the Student acknowledges the risks and potential for risks inherent in therapeutic riding, carriage driving, hippotherapy, vaulting, horsemanship and grooming; however believes the potential benefits are greater than the risks assumed.

Dated the day, month and year first above written.

Provider: Carlisle Academy Property Owner:

Student: _____ Legal Guardian: _____

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PARTICIPANT INFORMATION

Student Name: _____ **DOB:** _____

Student Address:_____

Phone: _____ **Height** _____ **Weight**_____

Guardian Name/Relationship to Student:_____

Email address: _____ **Phone:**_____

Guardian Address:_____

Facility/ Group home/Case Manager/Care Giver (Circle one if applicable)_____

Phone: _____ **Address:** _____

Diagnosis (If applicable)**:**_____

Medical history/surgeries (if applicable)**:** _____

Are you a veteran? Yes No (circle one) Branch of Military: _____

What are your goals?_____

_____

Photo/Video Release

I (circle one) **DO** **DO NOT** consent to and authorize the use and reproduction by Carlisle Academy Integrative Therapy & Sports any and all photographs and any other audio/visual materials taken of (student) _____ for promotional material, educational activities, exhibitions or for any other use for the benefit of the program.

Student/Legal Guardian: _____ Date: _____

Permission to Share Information with Lesson Volunteers

I (circle one) **DO** **DO NOT** Give permission to Carlisle Academy instructors to share information they deem appropriate regarding my son/daughter/ward and his/her disability/lesson goals/communication style, including any specific needs or precautions, with the lesson volunteers.

Student/Legal Guardian: _____ Date: _____

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Privacy Notice & Consent Form

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED. IT ALSO EXPLAINS HOW YOU CAN ACCESS THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We understand that privacy is a very important matter. Our work requires us to gather your personal health information (PHI) in order to provide services. We create a record of the services that you receive and you can trust us to keep your records confidential and secure.

Collecting Information: Carlisle Academy Integrative Equine Therapy & Sports LLC (hereinafter Carlisle Academy) restricts access to your PHI only to employees who need the information to provide you with the services. We maintain physical, electronic and procedural safeguards to comply with all laws and regulations to protect the privacy of your PHI.
Information Disclosure: Carlisle Academy will use and disclose your PHI so that our staff can provide you with services and/or ***Treatment***, to obtain ***Payment*** and to perform service delivery ***Operations*** (TPO). We review your PHI so that we can determine your program eligibility and sources of funding. The PHI that is disclosed may include: your name, address, social security number, phone number, diagnosis and disability, the name of your program funding source, and our documentation of your services.
Information Use: We do not sell your PHI to outside mailing lists or telemarketing companies. We will add your name to Carlisle Academy's mailing list in order to provide you with updated program information. We will contact you to schedule appointments or discuss service via the telephone, email or postal mail. You can specify the way you want us to communicate if it is necessary to protect your interests. Any other use or disclosure of your information (for Non-TPO purposes as described above) will require your written authorization. If you end your services with us, we will continue to restrict use of your PHI.
Your Rights: You have the right to restrict our use of your PHI, to review and copy our documentation of your services, to request changes to your information, to find out who we have disclosed your information to, and to file a complaint about our Privacy Practices. If you file a complaint, we will take no action against you or change your services in any way. To file a written complaint, please contact Sarah Armentrout at 207-985-0374. We reserve the right to amend this notice at any time.

FOR THE USE AND DISCLOSURE OF PERSONAL HEALTH INFORMATION (PHI) FORM TREATMENT, PAYMENT OR HEALTH CARE OPERATIONS

I hereby consent to the use and disclosure of my personal health information (PHI) by Carlisle Academy in order to carry out services and/or treatment, payment or health care operations. I have reviewed Carlisle Academy's Privacy Notice and have a copy of that notice.I have the right to request that the use and disclosure of my PHI be limited for services and/or treatment, payment and operations. I can revoke this Consent at any time by written request. I understand that Carlisle Academy may refuse to provide me with services if I do not sign this Consent.

Participant Name (printed)_____ Date_____

Participant Signature_____

Personal Representative/Guardian Signature_____

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Dear Physician/Mental Health Clinician,
Your client, _____, DOB: _____ with a permanent address of _____ is interested in participating in Equine Experiential Learning at Carlisle Academy. This is an unmounted equestrian program. All of The Academy's programs and instructors are accredited and credentialed by the Professional Association of Therapeutic Horsemanship, Intl (PATH, Intl.).
Please List any medications and their potential side effects:_____
_____

Please indicate any precautions or contraindications in the following systems/areas by checking the box.

Medical:	✓	***Comments:***
Sensory (visual, auditory, tactile)		
Cardiac		
Circulatory/Blood Pressure Control		
Immunity		
Pulmonary /Respiratory Compromise		
Neurologic		
Muscular		
Balance		
Orthopedic		
Allergies		*Allergy triggers:*
Pain		
Migraines		
Recent Surgeries		
Mental Health Disorder		
Animal Abuse/Fire Setting		
Suicidal Ideation/Danger to self or others		

This patient is not medically precluded from participation in Equine Experiential Education/Unmounted Program. I understand that Carlisle Academy will weigh the medical information with existing precautions and contraindications. Therefore, I refer this person to Carlisle Academy Integrative Equine Therapy & Sports for ongoing participation/evaluation.

Print Name/Title: _____ Professional Credentials: _____
Signature: _____ Date: _____ _____
Address: _____
Phone: ( ) _____ NPI Number: _____

Thank you for your assistance.
Please email this to Ally at aabrahamson@carlisleacademymaine.com. Note: Your patient will not be able to participate in our program without this documentation. Please call us at 207-985-0374 if you have any questions or concerns.