CARLISLE ACADEMY
INTEGRATIVE EQUINE
THERAPY & SPORTS

THERAPY SERVICES 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.

- Enrollment Form
- Participant Information Form
- Emergency Medical Form
- Liability and Inherent Risks Form
- Privacy Notice
- Therapy Medical Form signed by a Physician

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 staff to establish an individualized plan of care or find an appropriate program type. Carlisle staff will review the necessary paperwork for insurance benefits and other funding resources as needed, including scholarships through our charitable partner, the Carlisle Charitable Foundation.

3. Once the enrollment material is completed and the medical paperwork has been received, the student is enrolled in an upcoming session or placed on a waiting list. No student may begin at Carlisle until the necessary paperwork is received.

4. Enrollment midway through a session is considered on a case-by-case basis.

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

Sarah Armentrout, Head of School

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Enrollment Form – Therapy Services

Student Name: _____

Parent/Legal Guardian:_____

Phone: _____ **Email**: _____

School/Agency I attend with (if applicable):_____

Program Name: Hippotherapy ____Private (6 or 12 weeks) ____Semi-private (12 weeks only)
School/Agency Therapy Group _____(6 or 12 weeks)

Session: Spring Summer Fall

Payment:

Tuition/Per Diem Rate: $_____ _____Proration/Discount _____

Carlisle Charitable Foundation Scholarship (if applicable) _____

Other Funding Source: _____ Amount Pending/Received: _____

_____ I have read the Program Policies.

****

Scheduling Requests (circle all available):

Tuesday AM Tuesday PM Wednesday AM Wednesday PM Thursday AM Thursday PM

Specific Time Parameters:_____

Dates unable to attend (tuition still applies unless excused absence): _____

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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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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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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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**For Therapy Students Only

Dear Physician,

Your patient, _____, DOB: _____ is interested in participating in one of the following:

☐ **Physical and/or Occupational Therapy evaluation and treatment using all appropriate treatment methods including hippotherapy as a treatment tools.**

All of Carlisle Academy's programs and instructors are accredited and credentialed by the Professional Association of Therapeutic Horsemanship, Intl (PATH, Intl.). Carlisle Academy's therapists are Hippotherapy Clinical Specialists (advanced) by the American Hippotherapy Certification Board.

Patient Address: _____

City: _____ State: _____

Parent/Legal Guardian/Caregivers: _____

Address (if different):_____/Phone_____

Diagnosis Date of Onset: _____

(Circle one) Birth Childhood Adolescence Adulthood

Seizure Type: _____ Controlled: ***Yes*** ***No*** Date of Last Seizure: _____

Shunt Present: ***Yes*** ***No*** Date of Last Revision: _____

Special Precautions/Needs: _____

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

Braces/ Devices/Medical Equipment: _____

Medical & Surgical History: _____

_____

_____

For those with Down syndrome:

Neurologic Symptoms of Atlantoaxial Instability: _____ Present _____ Absent

Medication List (attach separate list if needed)

Medication	Dosing	Taken For	Potential Side Effects

Participant's Medical History and Physician's Statement

Participant Name: _____

DOB: _____ **Height:** _____ **Weight:** _____

(Note: Please provide us with the most recent weight of your patient as we have a 200lb weight limit for our riders to maintain the health and safety of our horses)

Please note: The following conditions may suggest precautions and contraindications to equine activities and therapy and we are not able to initial services without completion of this form. Please check off all relevant conditions. Existing neurological symptoms due to Atlantoaxial Instability (AAI) are contraindications for mounted activity.

Please indicate current or past special needs in the following systems/areas.

	✓	Comments	✓
Orthopedic		**Medical/Psychological**	
Atlantoaxial Instability-include neurologic symptoms		Allergies	
Coxa Arthrosis		Physical/Sexual/Emotional Abuse	
Cranial Defects		Animal Abuse	
Heterotopic Ossification/Myositis Ossifications		Blood Pressure Control	
Joint Subluxation/dislocation		Dangerous to self or others	
Osteoporosis		Exacerbations of medical conditions	
Pathologic Fractures		Fire Setting	
Spinal Fusion/Fixation		Heart Conditions	
Spinal Instability/Abnormalities		Suicidal Ideations	
Precautions due to joint replacement		Hemophilia	
Neurologic		Medical Instability	
Hydrocephalus/Shunt		Migraines	
Uncontrolled Seizures		PVD	
Spina Bifida		Respiratory Compromise	
Chiari II Malformation/Tethered Cord/Hydromelia		Recent Surgeries	
Other		Substance Abuse	
Age – less than 24 months		Thought Control Disorders	
Indwelling Catheters/Medical Equipment		Weight Control Disorders	
Medications			
Poor Endurance			
Skin Breakdown			

Comments: _____

_____

_____

_____

SUPPLEMENTAL: This diagnoses section is used for individuals seeking insurance reimbursement.

Check all that apply:

☐ **I am prescribing Physical or Occupational Therapy evaluation & treatment using all treatment strategies available at Carlisle Academy Integrative Equine Therapy & Sports.**

☐ **This patient is not medically precluded from participation in equine activities or therapy. 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: _____ MD DO NP PA Other: _____

Signature: _____ Date: _____

Address: _____

Phone: ( ) _____ NPI Number: _____

Thank you for your assistance. Please fax this to us at 207-985-7937. 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.