



Mailing Address: P.O. Box 23, Franconia, PA 18924

Location Address: 1 Highpoint Road, Perkasie PA 18944

Telephone: 215-822-2515

Website: www.ivyhillequestrian.org

Ivy Hill Therapeutic Equestrian Center. We strive to offer positive and productive therapeutic equestrian activities and services to individuals with disabilities.

To apply as a client to receive services at Ivy Hill, the first step is to complete and return our application packet. You will find these forms enclosed in this mailing, along with a self-addressed envelope for your convenience.

Once we receive your completed packet, our Physical Therapist and Program Director will review your information, and will contact you to schedule an intake evaluation appointment.

During the actual intake appointment, we will assess the applicant's physical, cognitive and social/emotional needs and determine if therapeutic riding services will be applicable. This evaluation lasts approximately one hour, and will include discussion of additional medical and treatment history, as well as an assessment done in the barn and while the applicant is mounted on a horse. At the conclusion of the intake evaluation, recommendations will be made for services with either our Physical Therapist or Therapeutic Riding Instructor staff, along with our preliminary goals and lesson plans for the applicant. At that time a weekly lesson schedule will be set.

Please feel free to contact us with any questions.

Sincerely,
The Staff at Ivy Hill

Fees (payable by cash or check):

- o Initial Intake Evaluation
 - With a Physical Therapist - \$70.00
 - With a certified Therapeutic Riding Instructor - \$55.00
 - With a certified Therapeutic Riding Instructor - Half Hour \$35
(for riders 6 and under- to be determined at appointment if hour is not appropriate)

- o Weekly session:
 - With a Licensed Physical Therapist
 - \$70.00 per 45 minute session
 - \$55.00 per 30 minute session
 - With a Certified Therapeutic Riding Instructor
 - \$35.00 per 50 minute private session
 - \$25.00 per 30 minute private session
 - \$25.00 per hour group session (if applicable)

Financial Aid is available for individuals who qualify. Please ask for an application.

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Rider's Registration

Client: _____ Date of Birth: _____

Street: _____ Phone number: _____

City/state/zip: _____

Email Address _____

School or Institute currently attending: _____

Contact Person (if applicable): _____

Parents/Guardians Name: _____

Address: _____

Daytime Phone Number: _____ Relationship: _____

_____ Relationship: _____

Evening Phone Number: _____ Relationship: _____

_____ Relationship: _____

In Case of Emergency Please Contact:

_____ Phone Number: _____

_____ Phone Number: _____

Availability:

Ivy Hill conducts lessons seven days a week. The more flexible you are the quicker we are able to schedule regular therapeutic riding sessions. Please Specify days and or times you are available.

Example: Mondays and Wednesdays after 4

Monday _____

Friday _____

Tuesday _____

Saturday _____

Wednesday _____

Sunday _____

Thursday _____

Receipts:

Monthly: ___ Quarterly: ___ Yearly: ___ None: ___

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Rider's Medical History and Physician's Statement

Name: _____ Date of Birth: _____

Address: _____

Name of Parent/Guardian: _____

Diagnosis: _____ Date of Onset: _____

Tetras Shot: Yes ___ No ___ Date: _____ Height: _____ Weight: _____

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

Medication: _____

**** For Persons with Down Syndrome:**

Cervical X-ray for Atlantoaxial Instability: Positive: _____ Negative: _____ X-ray date: _____

Please indicate if patient has a problem and/or surgeries in any of the following areas by checking YES or NO; if YES, please comment.

Areas	Yes	No	Comments
Auditory			
Visual			
Speech			
Cardiac			
Circulatory			
Pulmonary			
Neurological			
Muscular			
Orthopedic			
Allergies			
Learning Disability			
Mental Impairment			
Emotional/ Psychological Impairment			
Tactile Sensation			
Incontinence			
Coordination			
Balance			
Other			

Mobility: Independent Ambulation: Yes ___ No ___ Crutches: Yes ___ No ___

Braces: Yes ___ No ___ Wheelchair: Yes ___ No ___ Sits independently: Yes ___ No ___

Holds head up: 30 seconds ___ 2 minutes ___ No issues ___

Please indicate any special precautions: _____

To my knowledge there is no reason why this person cannot participate in supervised equestrian activities. However, I understand that the therapeutic riding center will weigh the medical information above, against the existing precautions and contradictions. I concur with a review of this person's abilities/limitations by a licensed/credentialed health professional (e.g. PT, OT, RN, Speech, Psychologist) in the implementation of an effective equestrian program.

Physician Name (please print or stamp)

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Date: _____

Physician Signature: _____

Contradictions to Therapeutic Horseback Riding

The following conditions, if present, may represent precautions or contradictions to therapeutic horseback riding. Please note whether these conditions are present, and to what degree.

Orthopedic	Yes	No	Mild	Moderate	Severe	Comments
Spinal Fusion						
Spinal Instabilities/Abnormalities						
Atlantoaxial Instabilities						
Scoliosis						Degree _____ Last X-Ray Date _____
Kyphosis						Degree _____ Last X-Ray Date _____
Lordosis						Degree _____ Last X-Ray Date _____
Hip Subluxation and Dislocation						
Osteoporosis						
Pathologic Fractures						
Coxas Arthrosis						
Heterotopic Ossification						
Osteogenesis Imperfecta						
Cranial Deficits						
Spinal Orthoses						
Internal Spinal Stabilization Device						
Fractures						

Medical/Surgical	Yes	No	Mild	Moderate	Severe	Comments
Allergies						
Cancer						
Poor Endurance						
Recent Surgery						
Diabetes						
Peripheral Vascular Disease						
Varicose Veins						
Hemophilia						
Hypertension						
Serious Heart Condition						
Stroke (CVA,TIA)						

Neurological	Yes	No	Mild	Moderate	Severe	Comments
Hydrocephalus/shunt						
Spina Bifida						
Tethered Cord						
Chiari II Malformation						
Hydromelia						
Paralysis 2 nd to Spinal Cord Inj.						
Seizure Disorder						

Muscular	Yes	No	Mild	Moderate	Severe	Comments
Hypotonic						
Hypertonic						
Trunk Control-Upper/Lower extremity, specify						

Secondary Concerns	Yes	No	Mild	Moderate	Severe	Comments
Behavior problems						
Age under two years						
Indwelling catheter						
Acute exacerbation of chronic disorder						

Further comments / Notes:

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CONSENT FOR RELEASE OF INFORMATION

Ivy Hill may request additional information for the purpose of developing an individual riding therapy program for the client named below. If we have your permission to obtain additional information from other therapeutic services, please complete this form.

I hereby authorize Ivy Hill Therapeutic Equestrian Program to receive information from the records of:

Client Name _____

The information to be released is checked below:

YES	NO	
		Medical history from a physician
		Physical Therapy evaluation, assessment and program plan
		Occupational Therapy evaluation, assessment and program plan
		Speech Therapy evaluation, assessment and program plan
		Classroom Individual Education Plan (I.E.P.)
		Psychological evaluation
		Other:

Signed: _____ Date: _____

Client (or Parent/Guardian, if client is under 18 years of age)

IMPORTANT

I agree to notify Ivy Hill, Inc. should the physical condition of the rider change at any time. Any operations or changes in medication must be made known to Ivy Hill immediately, and a new Prescription must be completed.

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Physician's Prescription

(To be used when a therapist is consulted. A therapist must have a prescription for each client he/she sees)

Client's Name: _____ Phone: _____

PRESCRIPTION FOR THERAPUTIC HORSEBACK RIDING/HIPPOTHERAPY

Prescription, where appropriate for evaluation and treatment by a Physical, Occupational and/or Speech Therapist in conjunction with the Therapeutic Horseback Riding Operating Center.

Recommended Frequency: _____

Precautions: _____

Physician's Signature: _____ Date: _____

Please Print, Type or Stamp

Physician's Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

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Down syndrome X-Ray Form (If Applicable)

Dear Client, Parent or Guardian,

There is a condition known as Atlanto-Axial dislocation or subluxation that may be present in some individuals with Down syndrome.

Parents or Guardians of children, or Clients with Down syndrome, who seek to participate in horseback riding with Ivy Hill, must be made aware of this condition known as Atlanto-Axial dislocation or subluxation, which can occur in 10 - 20 percent of individuals with Down syndrome. The two vertebrae at the top of the spinal column are named the atlas and axis respectively. In some persons with Down syndrome, the ligaments and bone structures that normally maintain the proper position of these vertebrae with respect to each other and the skull are abnormal. The abnormality permits under certain conditions of physical stress the spinal column to shift, which pinches the nerves issuing from the base of the brain, leading to severe consequences.

Because of this possibility, Ivy Hill, Inc wishes to protect persons with Down syndrome from activities such as horseback riding which could aggravate this condition until their doctor has examined them. The doctor will determine if the condition is present by an examination that requires an X-ray view of the neck when it is both flexed and extended. If the X-rays demonstrate that the Atlanto-Axial dislocation or subluxation is present, then the person with Down syndrome may not participate in horseback riding.

*Cervical radiograph for Atlanto _ Axial subluxation: Positive_____ Negative_____
Date of Radiograph:_____

Physician's Signature

Date

Physician's Printed Name & Title (MD or DO)

Phone

If Atlanto-Axial dislocation or subluxation is not present in an individual with Down syndrome, the individual may participate in the Ivy Hill Program.

Sincerely,

Ivy Hill Therapeutic Equestrian Center

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Liability Release Form

_____ (participant's name) would like to participate in the Therapeutic Horseback Riding programs offered by Ivy Hill Equestrian of Ivy Hill Foundation, Inc. By signing this form, I acknowledge the potential risks of injury or death from interacting with and riding horses. I hereby, intending to be legally bound, for myself, my heirs, executor or administrators, waive and release all claims for damages I may have against Ivy Hill Foundation, Inc., its Board of Trustees, Instructors, Therapists, Aides, Volunteers and/or Employees, and associates for any and all injuries, and/or losses I/my son/daughter/ward may sustain while participating at Ivy Hill.

Print name of Participant: _____

Is participant under 18 years of age? _____

If yes, Print name of Parent/Guardian: _____

Signature of Participant: _____

Signature of Parent/Guardian if participant is under 18 years of age: _____

Date: _____

Photo and Media Release - OPTIONAL

I hereby consent to and authorize the use and reproduction by Ivy Hill Foundation, Inc. and Ivy Hill Equestrian of any and all photographs and any other audiovisual and printed materials of me (or my son/daughter/ward if participant is under 18 years of age) for the promotional and educational activities or other uses for the benefit of the programs at Ivy Hill.

Print name of Participant _____

Is participant under 18 years of age? _____

If yes, Print name of Parent/Guardian: _____

Signature of Participant: _____

Signature of Parent/Guardian if participant is under 18 years of age: _____

Date: _____

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Authorization for Emergency Medical Treatment Form

Participant

Staff

Volunteer

Name: _____ DOB: _____ Phone: _____

Address: _____

Physician's Name: _____ Preferred Medical Facility: _____

Health Insurance Company: _____ Policy #: _____

Allergies to medications: _____

Current medications: _____

In the event of an emergency, contact:

Name: _____ Relation: _____ Phone: _____

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 _____ 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.

Date: _____ Consent Signature: _____

Client, Parent or Legal Guardian

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:

Date: _____ Consent Signature: _____

Client, Parent or Legal Guardian

Ivy Hill- Rider Questionnaire

The following questionnaire is designed to give Ivy Hill information pertaining to each individual rider's behavior and ability. This will help us prepare group lesson plans and assist you in attaining individual goals. Please complete the questionnaire in as much detail as possible using the back of the page or attaching an additional sheet if necessary.

Name: _____ Age: _____

1. Briefly describe his/her disability: _____

2. What are the physical symptoms of the disability? _____

3. What goals do you hope he/she will achieve by participating in this program? _____

4. What other treatments or therapies has he/she undergone? Please specify when and for how long: _____

5. How would you describe his/her concentration, attention span and general awareness? _____

6. Would you characterize him/her as happy, aggressive, easygoing, enthusiastic, passive, excitable, depressed, introverted or extroverted? _____

7. How does he/she communicate? (Expressive and Receptive language) _____

8. Is there a history of incontinence? _____

9. What positive reinforcements does he/she respond to? _____

10. Please use the rest of this sheet / the reverse side to indicate any other areas of the potential rider's behavior and personality that will help us to best communicate, understand and work with him/her at Ivy Hill _____

Completed by: _____ Date: _____

Relationship to Rider: _____

Ivy Hill- Client Policies and Guidelines

Payment

- ⊞ Payment must be received at the time of service unless other arrangements have been made.
- ⊞ Non-payment of two sessions will result in suspension of services until payment is received in full.
- ⊞ Repeated account delinquency will jeopardize your appointment slot.
- ⊞ Cash receipts or paid invoices can be generated available upon request. Please inform your Instructor or Physical Therapist so we can note this on your file.

Attendance and Cancellations

- ⊞ We appreciate 24 hours cancellation notice; please call your instructor directly in the event you need to cancel. We ask for advanced notice so that we are able to contact all staff, volunteers and therapists scheduled for your session to inform them of your cancellation.
- ⊞ Cancellations received less than three hours prior to session time may be charged a cancellation fee of \$20.00.
- ⊞ Excessive or repetitive cancellations will jeopardize your appointment slot.
- ⊞ Ivy Hill may close or cancel sessions due to inclement weather or uncomfortable temperatures. Ivy Hill will notify you with as much advance notice as possible. General temperature guidelines for canceling sessions are:
 1. Heat/humidity, over 95 degrees
 2. Cold/wind-chill below 20 degrees.

Guidelines for Sessions

- ⊞ Riders should arrive at the barn 5 minutes prior to the start of his/her session to allow the maximum use of the scheduled session time. Riders are not to be left unattended in the barn or on the property before the instructor/therapist starts the session or after the session. Ivy Hill staff cannot be responsible for supervising riders before or after the session time.
- ⊞ Proper dress of riders is required:
 1. Long pants (no shorts).
 2. Riding boots or shoes with a hard sole and low heel; no sandals, no loafers, no sneakers, no work boots (with lug soles).
 3. A safety-approved horseback-riding helmet (no bicycle helmets). Ivy Hill will provide helmets to borrow if the rider does not have his/her own.
 4. Riders should not wear large necklaces, bracelets or earrings that dangle, or excessively loose-fitting shirts or pants.
- ⊞ Barn rules for family and friends:
 1. Sandals are not permitted in the barn.
 2. Please do not hand-feed the horses - it can encourage biting. If you want to feed a treat, please ask permission from a staff person first, and place the treat in the horse's feed bucket.
 3. No running or yelling in the barn.
 4. No dogs allowed near or in the riding rings!
 5. Please allow our staff to conduct the lesson without interruption. When the session is taking place in the barn, please give the rider and staff room to work and without distraction. When the session is taking place in the ring, please keep conversation quiet.
 6. No spectators or family members allowed inside the riding ring during a session. Siblings should never be left unsupervised. All ring gates are to remain closed during the session.
 7. Our office is for staff only.

These rules and guidelines are for the safety of our riders and the productivity of our sessions. We appreciate your cooperation!