Registration Form

This packet must be turned in one week following reserving a spot via email to finalize your camper's enrollment. Email emma.bragg@myemail.inwes.edu to reserve a spot and turn in this packet. Physical copies may also be turned into TherAplay's front office at 9919 Towne Rd. Carmel, IN 46032. Enrollment will be based on spot availability and your camper's appropriateness for camp. Turning in this form does not guarantee enrollment.

Camp Requirements: **Have a medical diagnosis, participate in a small group of 5 kids with minimal support; communicate wants and needs effectively; be able to sit upright on the horse independently, transport onto horse with minimal to moderate assistance; tolerate transitions between environments every 30-40 minutes; and be under 100 lb for staff safety while on the horse.**

Child's name: _____

DOB: ___/___/___ Age: _____ School Grade: _____ Weight: _____ T-shirt size: _____

Preferred pronouns: _____

Address: _____

City: _____ State: _____ Zip: _____ County: _____

E-mail: _____

Is your child currently receiving services at Children's TherAplay? ____YES ____NO ____Graduated

Primary language: _____

Emergency/Primary Contact

Name: _____

Relationship to child: _____

Primary Guardian Cell #: _____Work # (if applicable): _____

Name: _____

Relationship to child: _____

Primary Guardian Cell #: _____Work # (if applicable): _____

Medical Information

Does your child have a seizure disorder? ____YES ____NO

Are the seizures controlled? ____YES ____NO Date of last seizure: ___/___/___

If YES to a seizure disorder, please fill out the Seizure Action Plan form attached to this packet.

Skills/Needs

Please check one for each item. I = Independent SA = Some Assistance TA = Total Assistance

Toileting: ____I ____SA ____TA

Comments: _____

Feeding: ____I ____SA ____TA

If not independent, please circle which of the following are applicable for assistance needed:

Special preparation (cut into small pieces, pureed, soft, etc.) Food allergies

Diabetic G-tube fed Diet restrictions

Bottle feeding Choking risk Assistance for opening containers

Assistance with feeding/ using utensils Picky eater

Food/snacks must be provided by parent

Comments: _____

Dressing: ____I ____SA ____TA

Comments: _____

Mobility: ____I ____SA ____TA

(In open environments, uneven terrain, stairs, etc.)

Comments (please note if child uses wheelchair, crutches, walker, etc.):

_____

Communication: ____Verbal ____Verbal (limited) ____Non-Verbal ____Sign Language

____ Assistive technology/ACC: _____

School Information

Does your child have a BIP, 504 or IEP in place? ____YES ____ NO

If YES, please attach plan to registration packet.

Percentage of school in traditional classroom setting:

____0-25% ____26-50% ____51-75% ____76-100%

Student/Teacher ratio: _____ Does your child have a one-to-one aid? ____YES ____NO

Services received *in school:*

____OT ____PT ____Speech ____Social Skills ____Adaptive PE ____ ABA _____ Other

Services received *out of school:*

____OT ____PT ____Speech ____Social Skills ____Adaptive PE ____ ABA _____ Other

Additional Information:

Can your child…

- Follow verbal directions? ◯ Y ◯ N
- Communicate personal needs? ◯ Y ◯ N
- Respect other's personal space? ◯ Y ◯ N
- Tolerate being told "no"? ◯ Y ◯ N
- Use supplies and equipment appropriately? ◯ Y ◯ N
- Stay on a *preferred* task for 10+ minutes? ◯ Y ◯ N
- Stay on a *non-preferred* task for 10+ minutes? ◯ Y ◯ N
- Tolerate adult-led activities? ◯ Y ◯ N
- Use appropriate language with others? ◯ Y ◯ N
- Follow multi-step instructions? ◯ Y ◯ N
- Stay with a group during activities and transitions? ◯ Y ◯ N

Comments:

_____

_____

_____

Please describe your child's ability to emotionally regulate (controlling big feelings, utilizing coping skills, delaying reactions, etc.):

_____

_____

_____

Please describe your child's ability to socialize with:

Siblings -

_____

_____

_____

_____

Peers -

_____

_____

_____

_____

Adults -

_____

_____

_____

_____

Does your child require any sensory needs? (sensory diet, sensory aversions, sensory seeker, etc.)
____YES ____NO If yes, please describe:

_____

_____

_____

Does your child have any behavioral difficulties? ____YES ____NO If yes, please describe:

_____

_____

_____

Does your child have difficulty expressing their needs? ____YES ____NO If yes, please describe:

_____

_____

_____

Does your child tolerate task transitions? ____YES ____NO If no, please describe:

_____

_____

_____

What areas regarding social and emotional skills would you like to see your child grow in?

_____

_____

_____

_____

_____

Please list all known diagnoses:

_____

_____

_____

Please use the space below to make us aware of anything else that will help best support your child such as supports or accommodations being used at school and/or at home:

_____

_____

_____

_____

_____

Lucky Farms, LLC/The Children's TherAplay Foundation, Inc.

Waiver, Release of Liability, Indemnification and Consent to Medical Attention

In exchange for the boarding of my horse(s) with Lucky Farms, LLC/The Children's TherAplay Foundation, Inc. and/or my participation in horse riding, horse riding lessons, horse riding clinics, hippotherapy (including various positioning and tandem hippotherapy) other equine activity sponsored by Lucky Farms, LLC/ The Children's TherAplay Foundation, Inc., I, and if I am not yet 18 years old (21 years old if out-of-state resident), my parent(s) or legal guardian(s) (individually and collectively referred to herein in the first person singular) agree to be bound by each of the following:

1. Voluntary Participation. I understand and confirm that the boarding of my horse(s) with Lucky Farms, LLC/ The Children's TherAplay Foundation, Inc. and/or my participation in horse riding, horse-riding lessons, horse riding clinics, hippotherapy (including various positioning and tandem hippotherapy) any other equine activity is voluntary.

2. Identification of Risks. I understand that the boarding of my horse(s) and/or my participation in the riding of horses, horse riding lessons, horse riding clinics, hippotherapy (including various positioning and tandem hippotherapy) any other equine activity may involve risk of injury and loss, to person, horse and to property. I also understand that the risk of injury may include the possibility of permanent disability and death to both person and horse. I understand that this Waiver and Release of Liability is intended to address all of the risks of any kind associated with the boarding of horse(s) and/or participation in any aspect of horse riding, horse riding lessons, horse riding clinics, hippotherapy (including various positioning and tandem hippotherapy) other equine activity; or with my involvement in any such equine activity, including, particularly, such risks created by actions, inactions, or negligence on the part of Lucky Farms, LLC/The Children's TherAplay Foundation, Inc. or its directors, officers, members, employees, agents, volunteers, successors or assigns, including but not limited to, risks created by the following: (a) the use of the equipment and tack, the premises and the facilities; (b) the determination of Lucky Farms, LLC/The Children's TherAplay Foundation, Inc. of a participant's ability to safely manage a particular horse or to engage in any particular horse riding activity; (c) the lack or inadequacy of policies, rules or regulations of the boarding premises and facilities and/or the horse riding lessons or clinics: (d) the failure of Lucky Farms, LLC/The Children's TherAplay Foundation, Inc. to foresee or protect me from actions, inactions, negligence, recklessness or intentional or criminal conduct of others; (e) the inadequacy or unavailability of medical facilities or treatment; (f) the lack or inadequacy of supervision; or (g) theft, fire, disease and other loss or damage.

3. Assumption of Risk. I assume all risks, known and unknown, foreseeable and unforeseeable, in any way connected with the boarding of my horse(s) and/or my participation in horse riding, horse riding lessons, horse riding clinics, hippotherapy (including various positioning and tandem hippotherapy) any other equine activity. I accept personal responsibility for any liability, injury, loss or damage in any way connected with the boarding of my horse(s) and/or my participation in horse riding, horse riding lessons, horse riding clinics, hippotherapy (including various positioning and tandem hippotherapy) any other equine activity. I assume the risk for not wearing a certified and approved riding helmet, saddles or other necessary equipment to protect my safely. I assume all risk and liability for my own injuries and damages and all injuries and damages of my horse(s). I assume all risk and liability while on the premises of Lucky Farms, LLC/The Children's TherAplay Foundation, Inc. and also while attending activities sponsored by Lucky Farms, LLC/The Children's TherAplay Foundation, Inc. that occur off the premises of Lucky Farms, LLC/The Children's TherAplay Foundation, Inc. I agree that Lucky Farms, LLC/The Children's TherAplay Foundation, Inc. is not liable for those persons that I invite as guests or as professionals to Lucky Farms, LLC/The Children's TherAplay Foundation, Inc. who may or may not ride horses while at Lucky Farms, LLC/The Children's TherAplay Foundation, Inc. I agree that Lucky Farms, LLC/The Children's TherAplay Foundation, Inc. does not assume the risk for those horses or persons that come to Lucky Farms, LLC/The Children's TherAplay Foundation, Inc. to visit me and I agree to inform my guests that if they are going to ride at Lucky Farms, LLC/The Children's TherAplay Foundation, Inc., they may not ride without signing this agreement.

4. Release and Waiver. I release Lucky Farms, LLC/The Children's TherAplay Foundation, Inc. and their directors, officers, members, managers, employees, agents, volunteers, successors and assigns from any and all liability for, and waive any and all claims for injury, loss or damage in any way connected with the boarding of my horse(s) and/or my participation in horse riding, horse riding lessons, horse riding clinics, hippotherapy (including various positioning and tandem hippotherapy) any other equine activity (a "Claim), whether or not caused in whole or in part by the negligence or other misconduct of Lucky Farms, LLC/The Children's TherAplay Foundation, Inc., or any of the individuals mentioned above.

5. Indemnification. I agree to indemnify and to hold harmless (in other words, to reimburse and to be responsible for) Lucky Farms, LLC/The Children's TherAplay Foundation, Inc. and its directors, officers, members, managers, employees, agents, volunteers, successors and assigns from all claims for any liability, injury, loss, damage or expense, including attorneys' fees (including the cost of defending any claim I might make, or that might be made on my behalf, that is released or waived by this instrument), in any way connected with or arising out of the boarding of my horse(s) and/or my participation in horse riding, horse riding lessons, horse riding

clinics, hippotherapy (including various positioning and tandem hippotherapy) any other equine activity, whether or not caused in whole or in part by the negligence or other misconduct of Lucky Farms, LLC/The Children's TherAplay Foundation, Inc. or any of the individuals mentioned above.

6. Binding Effect. This instrument shall be binding upon my relatives, personal representatives, heirs, beneficiaries, next of kin or assigns and shall inure to the benefit of Lucky Farms, LLC/The Children's TherAplay Foundation, Inc. and their respective successors and assigns.

7. Consent to Medical Treatment. I authorize Lucky Farms, LLC/The Children's TherAplay Foundation, Inc. to provide me, through medical personnel of its choice, customary medical assistance, transportation, and emergency medical services. This consent does not impose a duty upon Lucky Farms, LLC/The Children's TherAplay Foundation, Inc. to provide such assistance, transportation or service. I understand that if I do not authorize medical assistance, transportation or emergency medical services under this paragraph, neither Lucky Farms, LLC, nor The Children's TherAplay Foundation, Inc., shall have any duty whatsoever to provide any form of assistance in the event I may be injured in any manner contemplated by this document.

8. Severability. If any term or provision of this instrument or the application thereof to any persons or circumstances shall to any extent or for any reason be invalid or unenforceable, the remainder of this instrument and the application of such term or provision to persons or circumstances other than those as to which is held invalid or unenforceable shall not be affected thereby, and each term and provision of the instrument shall be valid and enforced to the fullest extent permitted by law.

9. Applicable Law. Because Lucky Farms, LLC/The Children's TherAplay Foundation, Inc. is located in the State of Indiana, and in order to provide certainty in the law to be applied to the construction of this instrument, this instrument shall be governed, construed and enforced in accordance with the law of the State of Indiana.

This is a waiver and release of liability. I have read this waiver, release of liability, indemnification and consent. I understand that I have given up substantial rights by signing it. I am signing this waiver, release of liability, indemnification and consent voluntarily.

Printed Name Signature Date

If the person participating in the program is not yet 18 years old (21 years old if out-of-state resident), **ALL** custodial parents or legal guardians must also sign:

In exchange for my/our child or ward being allowed to board his/her horse(s) with Lucky Farms, LLC/The Children's TherAplay Foundation, Inc. and/or participate in horse riding, horse riding lessons, horse riding clinics, hippotherapy (including various positioning and tandem hippotherapy) any other equine activity, and as the custodial parent(s) or legal guardian(s) of the above- named individual, I/we verify that I/we fully understand, agree to and accept all provisions of this waiver, release of liability, indemnification and consent.

Printed Name (Parent or Guardian) Signature Date

Printed Name (Parent or Guardian) Signature Date

The Children's TherAplay Foundation, Inc.

Photography Release

I give permission for myself to be photographed (still or video photography). I understand that any photography will be used for promotional purposes for The Children's TherAplay Foundation, Inc. There will be no monetary gain for the exchange or use of any photographs. My first name will be the only name used during the presentation.

_____

Name (printed)

_____

Signature

_____

Date

Children's TherAplay
The Children's TherAplay Foundation, Inc.

Authorization for the Disclosure of Protected Health Information

1. 1. Child's Name: _____ Parent/Guardian's: Name: _____

2. By signing below, I hereby authorize my child's Protected Health Information to be disclosed. The Protected Health Information I am authorizing for disclosure is the following:

   ☐ "Standard" release of all information maintained by Children's TherAplay Foundation, Inc. (Includes evaluation, daily therapy notes and progress notes, etc.)

   ☐ Specific information from my child's chart: _____

3. The person or group of people who are authorized to disclose my child's Protected Health Information are as follows: The Children's TherAplay Foundation, Inc.

4. I hereby request The Children's TherAplay Foundation, Inc. to disclose my child's Protected Health Information to the following person(s) or institutions(s):
   - Name of person or parties to receive your child's medical information: _____
     _____
   - Please indicate where we should mail your child's medical information (or any alternative instructions for delivery, such as email or fax): _____

5. This authorization will expire 60 days from signing, unless an alternative date is indicated: _until child is discharged from services at Children's Theraplay_____

6. I understand that I have the right to revoke this Authorization, if the revocation is in writing, at any time by sending a written request to The Children's TherAplay Foundation, 9919 Towne Road, Carmel, IN 46032. I am aware that my revocation will not be effective regarding the uses and disclosures of content by Children's TherAplay made in reliance on this HIPAA Authorization and that have been made prior to receipt of my revocation.

7. I understand that The Children's TherAplay Foundation, Inc. may not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization.

8. I understand that my child's Protected Health Information that is disclosed under this Authorization may be subject to re-disclosure by the recipient, and the privacy of my child's Protected Health Information will no longer be protected by the law.

9. I understand that if I am requested to sign this Authorization by The Children's TherAplay Foundation, Inc., that (i) I will be given a copy of this Authorization; (ii) I may inspect or copy the information to be used or disclosed; and (iii) I may refuse to sign this Authorization.

   By signing this Authorization, I acknowledge that I have read and understand this Authorization. Further, I authorize the disclosure of my child's Protected Health Information in accordance with the terms of this Authorization.

_____ _____

Signature of Parent or Guardian Signature of Parent or Guardian

_____ _____

Date Date

CYW Adverse Childhood Experiences Questionnaire (ACE-Q) Child

To be completed by Parent/Careqiver

Today's Date: _____

Child's Name: _____ *Date of birth:* _____

Your Name: _____ *Relationship to Child:* _____

Many children experience stressful life events that can affect their health and wellbeing. The results from this questionnaire will assist your child's doctor in assessing their health and determining guidance. *Please read the statements below. Count the number of statements that apply to your child and write the total number in the box provided.*

Please DO NOT mark or indicate which specific statements apply to your child.

1) Of the statements in Section 1, HOW MANY apply to your child? Write the total number in the box. ☐

Section 1. *At any point since your child was born...*

- Your child's parents or guardians were separated or divorced
- Your child lived with a household member who served time in jail or prison
- Your child lived with a household member who was depressed, mentally ill or attempted suicide
- Your child saw or heard household members hurt or threaten to hurt each other
- A household member swore at, insulted, humiliated, or put down your child in a way that scared your child OR a household member acted in a way that made your child afraid that s/he might be physically hurt
- Someone touched your child's private parts or asked your child to touch their private parts in a sexual way
- More than once, your child went without food, clothing, a place to live, or had no one to protect her/him
- Someone pushed, grabbed, slapped or threw something at your child OR your child was hit so hard that your child was injured or had marks
- Your child lived with someone who had a problem with drinking or using drugs
- Your child often felt unsupported, unloved and/or unprotected

2) Of the statements in Section 2, HOW MANY apply to your child? Write the total number in the box. ☐

Section 2. *At any point since your child was born...*

- Your child was in foster care
- Your child experienced harassment or bullying at school
- Your child lived with a parent or guardian who died
- Your child was separated from her/his primary caregiver through deportation or immigration
- Your child had a serious medical procedure or life threatening illness
- Your child often saw or heard violence in the neighborhood or in her/his school neighborhood
- Your child was often treated badly because of race, sexual orientation, place of birth, disability or religion

Seizure Action Plan

Supplemental Form

Participant Name: _____ **Date:** _____

Basic Information: Please provide background information on the nature of the seizures (i.e. type, triggers, length, etc.)

Seizure Type	Length	Frequency	Description

1. Are there triggers/warning signs? _____

_____

2. How will the participant respond/behave once the seizure is over? _____

_____

History & Management of Seizures:

1. When was the participant's last seizure? _____
2. Has the participant been hospitalized for continuous seizures? ☐ yes ☐ no
3. Does the participant have a Vagus Nerve Stimulator (VNS?) ☐ yes ☐ no

   B. Describe use of the magnet: _____

   _____

4. Does the participant take medication(s) for their seizures? ☐ yes ☐ no

   A. Will this medication need to be administered at the Respite event? ☐ yes ☐ no

Medication	Dose	Route of administration (i.e: oral, rectal, etc.)	The medication is for emergencies only
			☐ yes ☐ no
			☐ yes ☐ no
			☐ yes ☐ no

Seizure Emergency Protocol: please list out directions for staff to follow in the instance that the participant has a seizure during a Respite event.

If the participant has a typical seizure please do the following…	Call 911 immediately if…	Administer Diastat or utilize VNS magnet if….
1. 2. 3. 4. 5.		

Basic Seizure First Aid:

- Stay calm and track the time
- Keep child safe
- Do not restrain
- Do not put anything in mouth
- Stay with the child until they are fully conscious
- Protect the head
- If tonic, clonic, place child on side and keep airway open for breathing

By signing below, I acknowledge that the information provided above is the most recent and up-to-date medical information for the above listed participant. In the event of an emergency, I give my permission for Children's TherAplay to seek emergency medical care and treatment from the physician and/or hospital that I have identified on the Camp Registration Forms. I understand that I am responsible for payment of any emergency medical care.

_____ _____

Parent Signature **Date**

For staff use only:

This form was received and reviewed by:

_____ _____

Name / Title **Date**