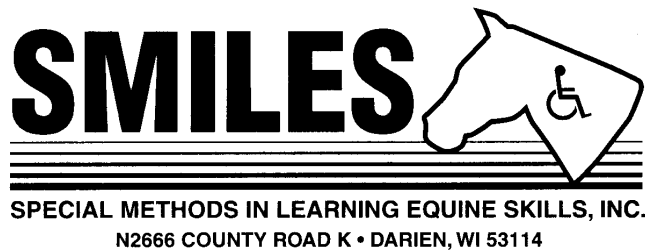


Phone
(262) 882-3470
Fax
(262) 882-5661



E-mail
classes@smiles.nu
Website
www.smiles.nu

Dear 2010 SMILES Rider,

Welcome to SMILES! Due to the large number of student requests, it is very important that we receive your student forms and fees as soon as you have decided to participate in SMILES. With your cooperation, we will be able to plan quality lessons and decrease the risk of your inability to participate due to the lack of forms received. **All forms must be received prior to riding and need to be updated annually.**

Our sessions for the 2010 riding season are as follows:

Winter II	January 4-30 (4weeks)	Summer I	June 7-July 10(5 weeks)
Winter III	February 15-March 13 (4 weeks)	Summer II	July 23-August 25 (5 weeks)
Spring	March 29-May 22 (8 weeks)	Fall	September 13-November 6 (8 weeks)
		Winter I	November 29-December 18 (3 weeks)

Our student enrollment fees represent only a small portion of what it actually costs to provide each student with the benefits of therapeutic riding. The student cost of spring sessions are \$160.00 for each of the spring and fall sessions, \$100.00 for each of the summer sessions, \$60.00 for winter I and \$80.00 for the winter II&III sessions. In addition, there is a nonrefundable, annual registration and processing fee of \$20.00. All fees or arrangements for payment must be made prior to the beginning of the session. **Payment for the full session is required.**

It is SMILES' goal as well as that of the Scholarship Committee, that no one ever be turned away due to financial difficulties. We will make every effort to work with you to obtain the assistance required for you to participate in the SMILES program. If you would like a Financial Assistance Application, please call the office and one will be sent to you.

All students new to SMILES are to make an appointment with the office for a Pre-Class Evaluation. This evaluation is required to insure the proper horse and volunteer support for each rider. The Pre-Class Evaluation appointment will give the student time to visit the barn and the horses prior to their participation so that actual class time will not have to be used making this evaluation.

Depending upon class availability, SMILES offers inclusion classes for siblings of enrolled students. The fee for inclusion riders is: Spring and Fall -\$175 each session; Summer-\$125 each session; Winter - \$100.00 each session, plus the \$20 registration fee. Scholarships are not available for inclusion riders.

Hippotherapy is also available at SMILES provided by Form 2 Function LLC. Hippotherapy is a therapeutic treatment provided by a Physical and/or Occupational Therapist. For further information call the SMILES office.

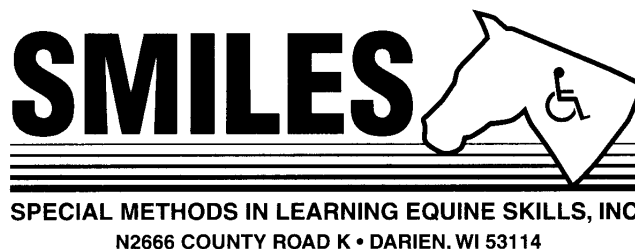
SMILES hopes to utilize email as much as possible. Please indicate if there is any correspondence or newsletter that you can't receive via email.

Anyone riding a SMILES horse must wear an ASTM approved helmet, available in the lounge or may be purchased at a tack shop.

Feel free to contact our office with any question or concerns that you might have. We look forward to hearing from you and seeing you in class!

Sincerely,
The SMILES Staff and Board of Directors
Contact Laurie by phone/e-mail listed above

Phone
(262) 882-3470
Fax
(262) 882-5661



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classes@smiles.nu
Website
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SCHEDULING REQUEST SHEET

Days of operation for Therapeutic Riding: Monday, Tuesday, Thursday & Saturday
Hippotherapy: Wednesday & Friday.

Please check all sessions you wish to participate in:

8 wk Spring___ 5 wk Summer 1___ 5 wk Summer II___ 8 wk Fall___

3 wk Winter I___ 4 wk Winter II___ 4 wk Winter III___

Please list your first, second, and third choices for class times:

1st _____ 2nd _____ 3rd _____

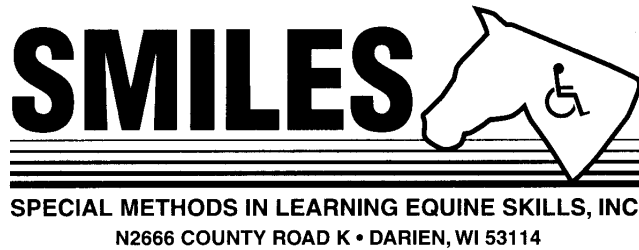
Due to limited class space, SMILES does not credit or refund classes that are missed. If SMILES cancels, and no reschedule time is available, you will be credited on a pro-rated basis.

SMILES bills for sessions rather than classes and , all sessions must be paid in full at the beginning of the session.

Please let us know in advance if you will be absent from a class so that volunteers and horses will not be waiting for you to arrive.

**For weather cancellations the following radio stations will be broad casting our closing:
WFAW a.m.940/,Lite f.m. 107.3/ WSJY107.3/, Kool f.m. 106.5/, WLKG 96.1/, WSLD 104.5**

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RIDERS REGISTRATION AND RELEASE FORM

DATE: _____ RIDER'S NAME: _____ DOB: _____

STREET: _____ CITY: _____ ZIP: _____

COUNTY: _____ HOME PHONE: (_____) _____

WORK #: (_____) _____ CELL # (_____) _____ EMERGENCY # (____) _____

E-MAIL ADDRESS _____ E-NEWSLETTER

PARENT OR GUARDIAN _____

PARENT OR GUARDIAN PLACE OF EMPLOYMENT _____

ADDRESS/PHONE: _____ ETHNIC GROUP _____

SEX _____ WEIGHT _____ HEIGHT _____ SCHOOL/GROUP HOME _____

PRIMARY DISABILITY: _____ OTHER DISABILITIES _____

ADAPTATIONS: _____ HAS STUDENT EVER RIDDEN A HORSE: _____

LIKES/DISLIKES (SPORTS, GAMES, REINFORCEMENTS) _____

PHYSICAL FUNCTION (Mobility, transfer skills, walking) _____

PSYCHO/SOCIAL FUNCTION _____

GOALS (What benefits would you like to obtain through riding?) _____

PHOTO RELEASE

I do _____ **I do not** _____

Consent to and authorize the use and reproduction by SMILES of any and all photographs and any other audio/visual materials taken of me for promotional material, educational activities, exhibitions or for any other use for the benefit of the program.

Signature _____ Date _____

Client, Parent or Guardian

LIABILITY RELEASE

_____ (Rider's name) would like to participate in the SMILES program. I acknowledge the risks and potential for risks of horseback riding. However, I feel the possible benefits to myself/my son/my daughter/my ward are greater than the risk assumed. I hereby, intending to be legally bound, for myself, my heirs and assigns, executors or administrators, waive and release forever all claims for damages against SMILES, its board of Directors, Instructors, Therapist, Aids, Volunteers and/or Employees for any and all injuries and /or losses I/my son/my daughter/my ward may sustain while participating in SMILES program.

Signature: _____ Date _____
Client, Parent or Guardian

RIDER'S AUTHORIZATION/EMERGENCY MEDICAL TREATMENT

In the event of an 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 SMILES 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.

EMERGENCY NUMBERS

IN CASE OF AN EMERGENCY CONTACT: _____ PHONE _____

OR CONTACT: _____ PHONE _____

Physician's Name: _____ Preferred Medical Facility _____

Health Insurance Co. _____ Policy # _____

(Please choose one plan below)

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 below is unable to be reached.

Date: _____ Print Name: _____ Phone: _____

Consent Signature _____

NON-CONSENT PLAN

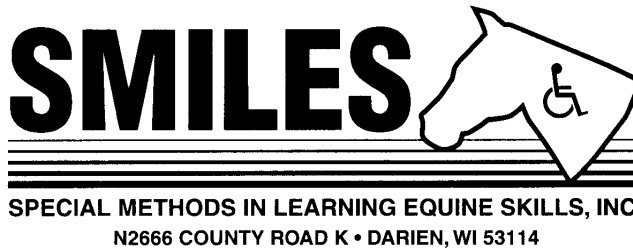
I do not give my consent for emergency medical treatment/aid in the case of illness or injury during the process of receiving services or while being on the property of SMILES. In the event emergency treatment/aid is required, I wish the following procedures to take place:

Date: _____ Print Name: _____ Phone: _____

Non-consent Signature: _____

Client, Parent or Guardian

Phone
(262) 882-3470
Fax
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E-mail
classes@smiles.nu
Website
www.smiles.nu

Participant's Medical History & Physician's Statement

Participant: _____ DOB: _____ Height: _____ Weight: _____
 Address: _____
 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: _____

Mobility: Independent Ambulation Y N Assisted Ambulation Y N Wheelchair Y N

Braces/Assistive Devices: _____

For those with Down Syndrome: AtlantoDens Interval X-rays, date: _____ Result: + --

Neurologic Symptoms of AtlantoAxial Instability: _____

Please indicate current or past special needs in the following systems/areas, including surgeries:

	Yes	No	Comments
Auditory			
Visual			
Tactile Sensation			
Speech			
Cardiac			
Circulatory			
Integumentary/Skin			
Immunity			
Pulmonary			
Neurologic			
Muscular			
Balance			
Orthopedic			
Allergies			
Learning Disability			
Cognitive			
Emotional/Psychological			
Pain			
Other			

Name/Title: _____ MD DO NP PA Other _____

Signature: _____ Date: _____

Address: _____

Phone: () _____ License/UPIN Number: _____

Given the above diagnosis and medical information, this person is not medically precluded from participation in equine assisted activities. I understand that the NARHA center will weigh the medical information given against the existing precautions and contraindications. Therefore, I refer this person to the NARHA center for ongoing evaluation to determine eligibility for participation

Possible Contraindications listed on next page

Please note that the following conditions may suggest precautions and contraindications to therapeutic horseback riding. Therefore, when completing this form, please note whether these conditions are present, and to what degree.

ORTHOPEDIC

Atlantoaxial Instability – include neurologic symptoms
Coxa Arthrosis
Cranial Deficits
Heterotopic Ossification/Myositis Ossificans
Joint subluxation/dislocation
Osteoporosis
Pathologic Fractures
Spinal Joint Fusion/Fixation
Spinal Joint Instability/Abnormalities

NEUROLOGIC

Hydrocephalus/Shunt
Sensory Deficit
Seizures
Spina Bifida/Shiari II malformation/Tethered Cord/Hydromyelia

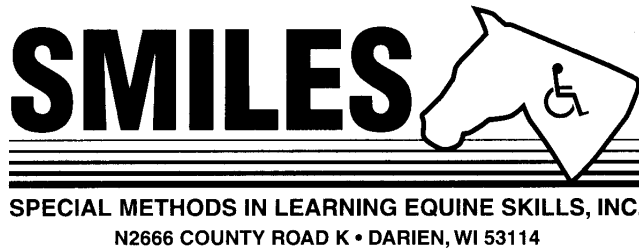
OTHER

Age – under 4
Indwelling Catheters/Medical Equipment
Medications – i.e. photosensitivity
Poor Endurance
Skin Breakdown

MEDICAL/PSYCHOLOGICAL

Allergies
Animal Abuse
Cardiac Condition
Physical/Sexual/Emotional Abuse
Blood Pressure Control
Dangerous to self or others
Exacerbations of medical conditions (i.e. RA, MS)
Fire Settings
Hemophilia
Medical Instability
Migraines
PVD
Respiratory Compromise
Recent Surgeries
Substance Abuse
Thought Control Disorders
Weight Control Disorder

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RIDER DISMISSAL POLICIES

These policies were established to insure the quality and safety of our lessons for both students and volunteers.

Any rider 175 pounds or more must be able to remain centered and be balanced enough to not require side walkers for physical assistance.

SMILES can not accommodate a rider over 275 pounds to insure the horse can safely carry their rider.

Students may be dismissed from the program for the following reasons. This determination will be made by the Instructor and the Director of Instruction. If a rider is dismissed from the SMILES program, a prorated refund will be issued.

- * Unsafe, combative, or disruptive behavior toward staff, volunteers, or horses by students, guardians, or visitors.
- * Deterioration of health to a point where riding becomes a contraindication to their well being
- * Missing 3 consecutive lessons unless absences are for medical reasons or unless previously approved.
- * Destruction of SMILES property by students, guardians, or visitors.
- * As our horses age, some are retired and some require weight limits. We strive to keep all of our horses healthy, sound and safe. However, there may be times where the horses available may not be suitable for certain riders. This determination will be made on an ongoing basis.

All persons involved with the SMILES program (students, guardians, visitors, and volunteers) must adhere to the barn rules as posted in washrooms and barn aisle.

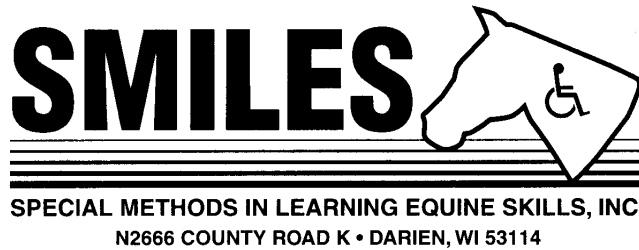
If a person is not eligible for riding, SMILES offers the HEARTS (Horse Experiences and Activities Resulting in Therapeutic Success) program as an alternative. This program allows the student to interact with the horse by grooming, feeding, care and nurturing in a safe environment.

SMILES preserves the right of confidentiality for all medical, social, referral, personal and financial information for all individuals involved in its program

We want your experience in the SMILES program to be one that is both fun and rewarding for all involved!

Parent/Guardian Signature _____

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THERAPY FORM (Optional)

NOTE: If the student is presently undergoing physical or occupational therapy, the therapist is to complete this form.

Rider's Name _____ Date of Birth _____

Address _____ City _____ State _____ Zip _____

Disability _____ School _____

Contact Person _____ Phone _____

Muscle Tone _____ ROM/JT. Deformities _____

Balance/Coordination _____

Self-Help Skills _____

Mobility _____

Assistive Devices _____

Posture/Scoliosis _____

Associated reactions/abnormal reactions _____

Comprehension of verbal instructions _____

Speech _____

Psychological/Behavioral _____

Exercises/Positions to Avoid _____

Other Special Precautions _____

Present Goal of PT/OT/Speech Program _____

Signed _____ Date _____