



N2666 County Rd K Darien WI 53114

Office: (262)882-3470 · Fax: (262) 882-5661

classes@smiles.nu · www.smiles.nu

Dear 2012 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 student enrollment fees represent only 25% of what it actually costs to provide each student with the benefits of therapeutic riding. The other 75% is made up from SMILES fundraisers, grant writing, and donations from various sources.

The student's share of Winter, Summer, Spring and Fall sessions are \$315.00 each or 270.00 if paid in advance (one week before the session begins).

HEARTS \$160.00 in paid in advance (one week before session begins) or \$180.00.

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

2012 SESSIONS:

- Winter January 16th -March 17th
- Spring April 2nd- June 2nd
- Summer June 25th—August 25th
- Fall October 1st- December 1st

Sessions falling on holidays will be pro-rated.

session. **Payment for the full session is required.**

SMILES offers limited scholarship to those that qualify.

If you would like a Financial Assistance Application, please call the office and one will be sent to you.

If personal circumstances would allow you to pay more than our standard enrollment fee, adding any amount would help us fill the gap in funding. Please just make a note on your check or invoice.

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.

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/SEI approved helmet, which are available in the lounge or you may purchase your own at a tack shop.

Feel free to contact Laurie at the phone number or email listed above with any question or concerns that you might have. We look forward to hearing from you and seeing you in class!

Sincerely,

SMILES Staff and Board of Directors





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SCHEDULING REQUEST SHEET

Days of operation for Therapeutic Riding: Monday, Tuesday, Thursday & Saturday

Days of operation for Hippotherapy: Wednesday & Friday.

Please check all sessions you wish to participate in:

9 wk Winter ___ 9 wk Spring ___ 9 wk Summer ___ 9 wk Fall ___

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

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.

***** Clip & Save For Future Reference *****

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 _____ CITY _____

ETHNIC GROUP _____ SEX _____ WEIGHT _____ HEIGHT _____

SCHOOL/GROUP OR 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:

Secure and retain medical treatment and transportation if needed.

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 # _____

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 _____



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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: _____

	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

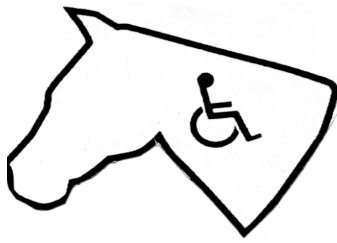
Signature: _____ Date: _____

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 PATH International center will weigh the medical information given against the existing precautions and contraindications. Therefore, I refer this person to the Path International center for ongoing evaluation to determine eligibility for participation.

Possible Contraindications listed on next page



E-mail

classes@smiles.nu

Website

www.smiles.nu

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

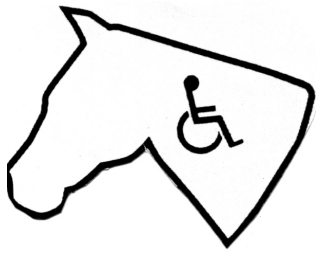
OTHER

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 150 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 200 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 Program Director. 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!

Rider/Parent/Guardian Signature _____



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To be completed by parent , guardian, teacher, or therapist.

To assist our instructors in formulating both their mounted and classroom lesson plans, please mark each item below that is an individual goal for this student. The skills can be directly applied to experiences at SMILES riding center. Within each category , PLEASE prioritize the item with #1 being the most important.

Physical Goals	Social & Recreational Goals	Cognitive/Educational Goals
<input type="checkbox"/> Improved balance	<input type="checkbox"/> Socialization	<input type="checkbox"/> Color recognition
<input type="checkbox"/> Improved posture	<input type="checkbox"/> Cooperation	<input type="checkbox"/> Shape recognition
<input type="checkbox"/> General coordination	<input type="checkbox"/> Sportsmanship	<input type="checkbox"/> Verbal recognition
<input type="checkbox"/> Eye/hand coordination	<input type="checkbox"/> Enjoyment	<input type="checkbox"/> Vocabulary Expansion
<input type="checkbox"/> Head control	<input type="checkbox"/> Confidence/self- esteem	<input type="checkbox"/> Sequencing
<input type="checkbox"/> Truck control	<input type="checkbox"/> Communication skills	<input type="checkbox"/> spatial awareness
<input type="checkbox"/> Muscular strength	<input type="checkbox"/> Attention (increase/decrease)	<input type="checkbox"/> Reading skills
<input type="checkbox"/> Gross motor skills	<input type="checkbox"/> Responsibility	a. letter recognition
<input type="checkbox"/> Fine motor skills	<input type="checkbox"/> Self-sufficiency	b. work recognition
<input type="checkbox"/> Decrease tactile defensiveness	<input type="checkbox"/> Social skill development	c. other
<input type="checkbox"/> Muscle tone	<input type="checkbox"/> Teamwork	<input type="checkbox"/> Math skills
<input type="checkbox"/> Sensory integration	<input type="checkbox"/> Independence	<input type="checkbox"/> a. number recognition
<input type="checkbox"/> Endurance	<input type="checkbox"/> Trust	b. add/subtract
<input type="checkbox"/> Visual/spatial orientation	<input type="checkbox"/> Interpersonal relationships	c. measurements

Describe personality strengths:

Learning style, please circle: Visual /learns by seeing Auditory/ learns by hearing Kinesthetic/ learns by doing