Accredited by the Middle States Association/Council on Elementary and Secondary Education

Bridgehampton Union Free School District

Dr. Lois R. Favre
Superintendente

P.O. Box 3021, 2685 Montauk Highway, Bridgehampton, NY 11932
Teléfono: (631) 537-0271 www.bridgehampton.k12.ny.us Fax: (631) 537-9038

17 Mayo, 2017

Estimado(s) Padre(s)/ Tutor(es):

Los estudiantes de quinto grado de la escuela de Bridgehampton están teniendo una oportunidad maravillosa este verano con una concesión proporcionada al centro para la equitación terapéutica del extremo del este (CTREE). Doce estudiantes tendrán la oportunidad de realizar un viaje de campo **los lunes (10, 17, 24, 31 Julio y 7 de Agosto), de mediodia a las 2 pm**, a las caballerizas de Wolfer en Sagaponack y participar en la preparación de caballos asi como otras actividades divertidas que serán planificadas para ellos por el personal de CTREE. Transportaremos a los estudiantes de la escuela y los regresaremos a la escuela.

Sólo hay 12 lugares disponibles y serán asignados en base a los paquetes completados que serán devueltos a la escuela, el 2 de Junio, y el compromiso de que su hijo estará disponible para todas las sesiones los lunes. Incluso los estudiantes que actualmente se inscribieron en nuestro campamento, pueden asistir a este programa los lunes y aún así mantener la inscripción en el campamento de verano en la colmena. En el caso de que se presenten más de 12 paquetes completados, realizaremos una lotería para determinar quién asistirá.

Adjunto encontrará los trámites necesarios, requeridos por CTREE. Usted notará que estos formularios son requeridos para cualquier persona que solicite un programa de equitación terapéutica en CTREE, y para propósitos de seguridad, todo el formulario debe ser completado y firmado. Si necesita ayuda para completar los formularios, ya que sólo estan disponible en inglés, comuníquese con la escuela y le aseguraremos que alguien esté disponible para ayudarle. **Si usted lleva los formularios médicos a su pediatra para completarlos, puede enviar los formularios completados y firmados a la escuela por medio de fax (número de fax arriba) y lo adjuntaremos a su paquete.**

Esperamos que su hijo aproveche este programa.

Sinceramente:

Lois R Favre

Dr. Lois R. Favre
Superintendente/Principal

Es la misión de la Escuela de Bridgehampton inspirar la curiosidad intelectual de vida y la expresión individual respetuosa alcanzando más allá de nuestra comunidad escolar y enseñando a todos los estudiantes las habilidades esenciales para participar activamente en la comunidad global y prosperar en el siglo XXI.

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May 17, 2017

Dear 5th Grade Parent/Guardian:

Fifth grade students at the Bridgehampton School are being given a wonderful opportunity this summer through a grant provided to the Center for Therapeutic Riding of the East End (CTREE). Twelve students will have the opportunity to take a field trip on **Mondays (July 10, 17, 24, 31 and August 7), from noon to 2PM,** to the Wolfer's Riding Stables in Sagaponack and take part in grooming, riding of horses as well as other fun activities that will be planned for them by CTREE staff. We will transport from the school and back to the school.

There are only 12 spots available and will be assigned based on completed packets being returned to the school, by June 2nd, and the commitment that your child will be available for all Monday sessions. Even students currently signed up for our camp, can attend this program on Mondays and still maintain enrollment in the Summer Camp at the Hive. In the event that more than 12 completed packets are submitted, we will use a lottery to determine who will attend.

Attached please find the necessary paperwork, required by CTREE. You will notice that these forms are required of anyone requesting a therapeutic riding program at CTREE, and for insurance purposes, all form must be completed, and signed. If you need assistance in completing the forms, as we only have availability in English, please contact the school and we will assure someone is available to assist. **If you take the medical forms to your pediatrician for completion, you can have them fax the completed and signed form to the school (fax number above) and we will attach it to your packet.**

We hope that your child takes advantage of this program.

Sincerely;

Lois R Favre

Dr. Lois R. Favre
Superintendent/Principal

It is the mission of the Bridgehampton School to inspire lifelong intellectual curiosity and respectful individual expression by reaching beyond our school community and teaching all students the essential skills to actively participate in the global community and to flourish in the 21st Century.

PO Box 1148, Bridgehampton, NY 11932-1148

Participant Eligibility Guidelines

CTREE will make every effort to meet the needs of all riders who apply for therapeutic riding.

However, the nature of these activities includes limitations, precautions and occasionally contraindications. These are due to a variety of causes, most notably the following:

- Size and weight-carrying ability of the available horses
- Nature of a disability or condition that would make it unsafe for an individual to ride
- Inability to schedule riding time to coincide with an individual's school or work schedule

Medical Precautions and Contraindications information is available for review by request from the Program Director.

Physicians Statement
All CTREE riders ***must*** have a signed and dated statement from their doctor.

Age
Therapeutic riding riders must be at least 5 years of age. Riders under the age of 5 are accepted under special circumstances.

Weight Limit
CTREE reserves the right to impose a weight limit in the event that no horse is available to safely carry a rider weighing over 170 pounds. A lower limit may be imposed if illness or injury prevents the use of a suitable horse.

Behavior
Inappropriate, unsafe or disruptive behavior or any condition where the client is harmful to him/herself or others is a contraindication to therapeutic horseback riding.

Evaluation/Re-evaluation
Each potential CTREE rider will receive an initial evaluation by a PATH Int'l. certified instructor. Based on this evaluation and the rider's medical reports, the rider will be advised if therapeutic riding is a recommended form of recreation.
Under certain conditions a rider's condition may change and a re-evaluation becomes necessary. Based on this re-evaluation, the rider may have to cease riding. A doctor's written verification is required for the rider to resume riding.

Thank you for understanding these guidelines. It is the intent of CTREE to provide the safest possible therapeutic riding lessons for our riders. If you have any questions, please do not hesitate to call us.

5/11,11/12

Participant Application

Page 1

General Information

Name ______________________________ Phone ______________

DOB __________ Age ______ Height ______ Weight ______ Gender M ___ F ___

Address ______________________________

Phone (home) ______________________ E-mail ______________________

Cell Phone ____________________ Preferred method of communication ___phone ___cell ___email

Employer/School ______________________________ Phone ______________

Address ______________________________

Parent/Legal Guardian ______________________________

Address (if different than above) ______________________________

Phone(s) ______________________________

Caregiver Name ______________________________ Phone ______________

Referral Source ______________________________ Phone ______________

How did you hear about our program? ______________________________

Health History

Diagnosis ______________________________ Date of Onset ______________

Please indicate current of past special needs in the following areas:

	Y	N	Comments
Vision			
Hearing			
Sensation			
Communication			
Heart			
Breathing			
Digestion			
Elimination			
Circulation			
Emotional/Mental Health			
Behavioral			
Pain			
Bone/Joint			
Muscular			
Cognitive			
Allergies			

Signature ______________________ Date ______________

Please complete both Page 1 and Page 2

Participant Application, Page 2

MEDICATIONS (include prescription, over-the-counter; name, dose and frequency)

____

____

____

____

____

LIABILITY RELEASE

It is understood that, being aware of the risks and exposures to personal injury involved through equestrian activities, I hereby release Center for Therapeutic Riding on the East End (CTREE) and Wolffer Estate Stables and its employees assisting in any official capacity on their behalf, from all and every claim for damages which may occur to me or property in any connection with any lesson, clinic, practice, schooling or any work with horses on the stable grounds or away from the grounds of the Wolffer Estate Stables, Sagaponack, New York.

Signature ______________________________ Date ____________________
(Client or parent/legal guardian)

PHOTOGRAPHY RELEASE

I hereby irrevocably consent _____ non-consent _____ to allow Center for Therapeutic Riding on the East End (Ctree) to use the photograph(s) and/or video(s) of me for any purpose, and in any manner, including without limitation to print media, social media, television, exhibition, publication, and any trade or advertising purpose, providing such uses are not made so as to constitute a direct endorsement by me of any product or service.

Signature ______________________________ Date ____________________
(Client or parent/legal guardian)

PHYSICAL FUNCTION (i.e. Mobility skills such as transfers, walking, driving, bus riding, etc.)

____

____

____

____

____

PSYCHOLOGICAL FUNCTION (i.e. Work/school including grade completed, leisure interests, relationships, family structure, support systems, companion animals, fears/concerns, etc.)

____

____

____

____

____

GOALS (i.e. Why are you applying for participation? What would you like to accomplish?)

____

____

____

____

____

Evaluation Date _______________

CTREE PARTICIPANT PHYSICIAN'S FORM – PAGE 2

Date: ______________________________

Dear Physician/Health Care Provider:

Your patient, __________________________________, is interested in participating in supervised equine activities.
(participant's name)

In order to safely provide this service, CTREE requests that you complete/update the Physician's Form, Page 1.

Please note that the following conditions may suggest precautions and contraindications to equine activities. 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
Seizure
Spina Bifida/Chiari II malformation/Tethered Cord/Hydromyelia
Other
Age - under 4 years
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

Thank you very much for your assistance. If you have any questions or concerns regarding this patient's participation in equine assisted activities, please feel free to contact me. I can be reached at 631-779-2835.

Sincerely,

Karen

Karen T. Bocksel
Managing Director

CTREE PARTICIPANT PHYSICIAN'S FORM – PAGE 1

Participant: ______________________ DOB: ________ **Height**: ______ **Weight**: _______
Address: ______________________
Diagnosis: ______________________ Date of Onset: ______________
Past/Prospective Surgeries: ______________________
Medications: ______________________
Seizure Type: ______________ Controlled? Y N Date of last seizure: ______________
Special Precautions, Diets/Needs: ______________________
May participate in all activities _______ May participate except for: ______________________
For those with Down Syndrome: Neurologic Symptoms of Atlantoaxial Instability: ____ Present ____ Absent

This participant is up-to-date on all the following routine childhood immunization :

	Y	N	Date
Measles			
Rubella			
Tetanus			
Pertussis			
Polio			
Diphtheria			
Other:			

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

	Y	N	Comments
Auditory			
Visual			
Tactile Sensation			
Speech			
Cardiac			
Circulatory			
Integumentary/Skin			
Immunity			
Pulmonary			
Neurologic			
Muscular			
Balance			
Orthopedic			
Allergies			
Learning Disability			
Cognitive			
Emotional/Psychological			
Pain			
Other			

IMPORTANT NOTE TO DOCTOR/MEDICAL FACILITY:
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 contraindications.
Name/Title: ______________________ MD DO Other: ______________
Signature: ______________________ Date: ______________
Address: ______________________

Authorization for Emergency Medical Treatment

☐ Rider ☐ Staff ☐ Volunteer

Name ______________________________ DOB __________ Phone ____________________

Address ____

Physician's Name, Town, Phone ____

Health Insurance Company ______________________________ Policy # ______________

Allergies to medication ____

Current medications and dosage ____

Caregiver Information: Name ______________________________ Phone _______________

Cell phone numbers: ____

Address (if different than above) ____

In the event of an emergency, contact:

Name ______________________________ Relationship __________ Phone ______________

Name ______________________________ Relationship __________ Phone ______________

Name ______________________________ Relationship __________ 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 Wolffer Stable I authorize Center for Therapeutic Riding in the East End (CTREE) to:

1. Secure and retain medical treatment and transportation if needed.
2. Release my medical, lesson 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 none of the persons listed above are unable to be reached.

Date ____________ Consent Signature ____
Client, Parent, or Legal Guardian

To my knowledge, the information I have given on this form is complete and accurate.

Date ____________ Signature ____
Client, Parent, or Legal Guardian

3/13

CTREE Rider Information

This information may be used by CTREE staff to assist in lesson planning for therapeutic riding.
Please complete the form to the best of your knowledge.

Name ______________________ Age ________ School ______________________

Please describe the rider's personality ____
____
____

List the rider's favorite activities ____

List any rider fears or dislikes (include any tactile, smell, hearing sensitivities) ____________________

Does the rider know/understand the following: *(explain below if needed)*

Educational/Cognitive	**Social**	**Language**
___Knows numbers	___Recognizes name	___Makes sounds/gestures
___Knows letters	___Knows word NO	___Says words
___Knows left and right	___Waves/says hello/bye	___Combines two or more words
___Knows prepositions	___Shares toys/items	___Speaks in complete sentences
___Describes feelings	___Understands rules	___Understands simple concepts
___Makes choices	___Appropriate touching	___Understands complex concepts
___Follows 1 step direction	___Interacts with peers	___Sounds out words
___Follows multi-step direction	___Appropriate conversation	___Recognizes sight words
___Good problem solving	___Makes eye contact	___Reads sentences

Rider communicates: _____verbally, _____with assistive device, _____ sign language, _____picture icons, _____ gestures, _____ sounds.

Check off the following physical skills that apply to the rider

___Stand on one foot	___Dresses self	___Opens doors/containers
___Hop/jump	___Rides a bike	___Uses utensils/tools
___Skip	___Plays sports	___Manipulates fasteners
___Weight bearing on hands	___Kick a ball	___Plays on swing
___Hold Object	___Catch a ball	___Writes legibly
___Release object		

Rider/Family Goals:

Signed ______________________ Relationship to Rider ______________ Date ____________

3/08