Mane Stream
PO Box 305 • Oldwick, New Jersey • 08858
Tel: (908) 439-9636 • Fax: (908) 439-2338
Web: www.manestreamnj.org

Dear Potential Participant:

Thank you for your interest in Mane Stream! Enclosed you will find information about our adaptive riding program, offered therapy services, and the appropriate application and forms. Please read all the information and complete all of the forms with required signatures. Please note that all signatures on these forms must be by an adult (over 18 years of age) or a parent/legal guardian. No other signatures will be accepted.

The following items are required to process an application:

1) Participant Application
2) Participant Information
3) Medical Release
4) Accident Waiver
5) Annual Medical History and Physician's Statement

When the completed paperwork is received in our office it will be reviewed by Mane Stream staff. You will be contacted by one of our staff members to schedule a free screening. This is an informal meeting where we review the services we offer, take a short ride on a horse or pony, and answer any questions that you may have. We will also discuss your goals and make a recommendation on which Mane Stream program would be a good fit for the participant. This free screening typically takes 10-20 minutes. Please be aware that not every child will get on the horse at the first screening. We will work with you to develop a plan to help your child become more comfortable and schedule additional screenings as needed. Please note that Mane Stream reserves the right to decline services if we do not have the appropriate resources available to provide services safely.

We are looking forward to meeting you soon!

Jennifer Dermody
Head Instructor
PATH Intl. Certified Advanced Instructor
jen@manestreamnj.org

Melanie Dominko-Richards, MS, CCC-SLP, HPCS
Coordinator of Therapy Services
Speech-Language Pathologist
melanie@manestreamnj.org

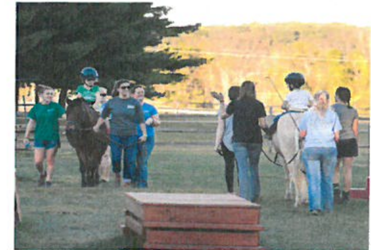
Mane Stream offers a wide variety of programs and services. This information sheet is to explain the different programs that we offer and to help you understand what will be the best fit for you and your family!

Adaptive Riding/Equine Assisted Activities

Adaptive riding is a horseback riding lesson taught by certified PATH International riding instructor where individuals learn horsemanship and riding skills. Lessons are held throughout the year and are weather dependent. Adaptive riding is not covered by insurance.

Mane Stream's Summer Camp is an inclusive day camp that teaches horsemanship and riding skills. Campers receive daily riding lessons, participate in horsemanship activities like grooming, tacking, leading, and basic horse care. Campers also play games, do arts and crafts, and make long lasting friendships!

Therapy Services



Occupational therapy sessions are conducted by a NJ licensed occupational therapist working one-on-one with the participant to achieve occupational therapy goals. Occupational therapy is designed for individual who wish to improve motor control, coordination, balance, attention, sensory processing, and performance in daily tasks.

Physical therapy sessions are conducted by a NJ licensed physical therapist working one-on-one with the participant to achieve physical therapy goals. Physical therapy is for individuals who wish to increase their balance, strength, endurance, and flexibility as well as improve their gross motor and mobility skills.

Speech-language therapy sessions are conducted with a NJ licensed speech-language pathologist working one-on-one with the participant to achieve speech-language therapy goals. Speech-language therapy is for individuals who wish to improve speech and language communication through augmentative communication, sign language, and verbal modalities.

Counseling services are conducted with a NJ licensed mental health professional, an equine specialist, and one or more equine partners. All work is done on the ground with no mounted activities. Sessions can be conducted with individuals, families, and/or groups through experiential activities with horses. Counseling services is for those who want to learn about themselves and others through experiential activities with the horses to process feelings, thoughts, and behaviors.

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PARTICIPANT APPLICATION

Participant Information

Participant's name: ______________________________ Preferred name: ________________________

Gender: M ❑ F ❑ DOB: ________________ County of residence: __________________________

Parent name: __________________________ Parent name: ___________________________________

Legal Guardian(s)(if other than parent):____

Miss❑ Ms.❑ Mrs.❑ Mr.❑ Mr. & Mrs.❑ Name: ____

Street: ____________________________ Town: ____________________ State: ______ Zip: _________

Contact Information

	Phone	Contact person		Phone	Contact person
Home:	________________	______________	Home:	________________	______________
Cell:	________________	______________	Cell:	________________	______________
Work:	________________	______________	Work:	________________	______________

Email: ________________________________ ❑ Email: ________________________________ ❑

Mane Stream prefers to use email for all correspondence. Please indicate which email all mailings should be sent to.

Group Home contact information (if applicable):

Supervisor name: ___________________ Phone: _____________ Email: _______________________

Primary contact name & phone numbers for cancellations, etc.:

1.) ______________________________ ________________________________ ❑ okay to text

2.) ______________________________ ________________________________ ❑ okay to text

How did you hear about therapy at Mane Stream? Please list the name of the person or source.

_____ Friend:____

_____ School/Teacher: ____

_____ Doctor: ____

_____ Other (*please specify):* ____

AUDIO-VISUAL RELEASE

I hereby: *(choose one)* ☐ **consent** to and authorize *or* ☐ **do not consent** to or authorize the use and reproduction of any and all photographs and any other audiovisual materials taken of me/my child by Mane Stream for promotional printed material, educational activities, website, Facebook and exhibitions, by PATH, AHA. Inc., EAGALA or for any other use for benefit of the Mane Stream program.

Participant/Legal guardian signature: ______________________________ Date: ________________

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PARTICIPANT INFORMATION

Identifying Information

Name: ______________________________ Age: ________ Today's Date: ______________

Participant's grade in school or educational level: ______________________________

School or employer: ______________________________

Personality Profile

Please describe the participant's personality:

____

____

____

____

List the participant's favorite activities and/or preferences?

____

____

____

____

List any fears or dislikes the participant may have?

____

____

____

____

Communication Preference

___ *verbally* ____ *assistive device* ____ *sign language*

____ *picture icons* ____ *gestures* ____ *sounds*

Assistive Devices

Please list any devices that the participant may use at home or school

Wheelchair: Power________________ Manual ________________

Stroller

Walker

Crutches/braces- ____

Stander

Gait trainer

Orthotics- ____

Splints- ____

Prosthetics- ____

Cervical collar, TLSO, abdominal binder, other trunk support

Other assistive devices- __________________________________

Participant/Family Goals

____

____

____

____

____

____

____

Mane Stream is a PATH Premier Accredited Center striving to provide the highest quality adaptive riding instruction and outpatient therapy for our participants. Thank you for taking the time to help us provide the best possible services.

Mane Stream
MEDICAL RELEASE

Participant:________________________________ **Date of Birth:** ________________
(Print Name)

Authorization:
In case of emergency I hereby authorize myself, my child or ward to be treated by Certified Emergency Personnel. (i.e. EMT, First Responder, E.R., Physician)

Family Physician: ________________________________ Phone: ________________
Address: ____
Hospital Preference: ____

In case of emergency contact:

____
Name Phone Number Relationship to Client

____
Name Phone Number Relationship to Client

Please list any allergies/medical problems, including those requiring maintenance medications (i.e. Diabetic, Asthma, Seizure Disorder).

____

____

____

Date of last seizure:____

The purpose of the above listed information is to ensure that medical personnel have details of any medical problem which may interfere with or alter treatment.

Medical Diagnosis	Medication	Dosage	Frequency of Dosage

Date of last Tetanus Toxoid Booster: ________________________________

________________________________ ________________________
Participant Signature **Date**

Mr./Mrs./Ms. ________________________ ________________________
Authorized Parent/Guardian Signature **Date**

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Mane Stream

ACCIDENT WAIVER AND RELEASE

In consideration of being permitted to participate in the equine related services and activities at Mane Stream, Inc., ("Mane Stream") located in Oldwick, New Jersey (collectively referred to as the "Activity") I, ______________________________, on behalf of myself OR on behalf of ______________________________, hereby:

1. Acknowledge and agree that I am voluntarily participating in the event of my own free will.

2. Fully understand that the Activity involves risks and dangers, including but not limited to property damage, bodily injury, disability and possibly death. I understand that these risks may be caused by the nature of the Activity itself, the use or misuse of equipment, my own action or inaction, the action or inaction of others participating in the Activity or the action or inaction of the Releasees (named below).

3. Understand and acknowledge that I am voluntarily assuming all risks associated with or arising out of participating in this Activity, whether foreseeable or unforeseeable, including but not limited to those risks described in paragraph 2 above.

4. Acknowledge, agree and represent that I understand the nature of the Activity and that I am qualified and physically able to participate in such Activity. I further agree and warrant that if at any time I believe conditions to be unsafe, I will immediately discontinue further participation in the Activity.

5. Agree to release Mane Stream and any of its owners, administrators, directors, agents, officers, members, volunteers, employees, successors and assigns (each, a "Releasee" and collectively, the "Releasees") from any and all claims past, present and future, known or unknown, that I, my heirs, executors, administrators or any other person on my behalf may have and that arise in connection with my participation in the Activity.

6. Agree to indemnify Releasees for, from and against each and every demand, claim, loss (which shall include any diminution in value), liability, judgment, damage, cost and expense (including, without limitation, interest, penalties, costs of preparation and investigation, and the reasonable fees, disbursements and expenses of attorneys, accountants and other professional advisors) (collectively, "Losses") suffered by any and all of the Releasees as a result of my participation in the Activity, including, but not limited to, Losses sustained as a result of a third-party claim against the Releasees arising from participation in the Activity, Losses sustained by Releasees in seeking medical treatment for me in connection with my participation in the Activity, and/or Losses resulting from Releasees' efforts to enforce this Waiver and Release.

7. Acknowledge and understand that Releasees are not responsible for the actions or inactions of any third parties hosting or conducting any event or activities related to the Activity.

8. Understand and acknowledge that this Waiver and Release is governed in all respects by the laws of the State of New Jersey, irrespective of conflicts of laws rules.

9. Acknowledge that I, or the person I am signing on behalf of is receiving valuable consideration through participation in the Activity, the receipt and sufficiency is hereby acknowledged.

I HAVE READ THIS WAIVER AND RELEASE, FULLY UNDERSTAND ITS TERMS, UNDERSTAND THAT I HAVE GIVEN UP SUBSTANTIAL RIGHTS BY SIGNING IT AND HAVE SIGNED IT FREELY AND WITHOUT INDUCEMENT OR ASSURANCE OF ANY NATURE AND INTEND IT TO BE A COMPLETE AND UNCONDITIONAL RELEASE OF ALL LIABILITY TO THE GREATEST EXTENT ALLOWED BY LAW AND AGREE THAT IF ANY PORTION OF THIS AGREEMENT IS HELD TO BE INVAVLID, THE BALANCE, NOTWITHSTANDING, SHALL CONTINUE IN FULL FORCE AND EFFECT.

Full Name (print): ______________________________

Signature: ______________________________ Date: ____________________

OVER PLEASE

Mane Stream

ACCIDENT WAIVER AND RELEASE

PARENT / GUARDIAN WAIVER FOR MINORS OR WARDS

The undersigned parent and/or guardian does hereby represent that he/she is, in fact, acting in such capacity, has consented to his/her child or ward's participation in the Activity, and has agreed individually and on behalf of the child or ward to the terms of the accident waiver and release of liability set forth above. The undersigned parent or guardian further agrees to save and hold harmless and indemnify each and all of the parties referred to above from all liability, loss, cost, claim, or damage whatsoever which may be imposed upon said parties because of any defect in or lack of such capacity to so act and release said parties on behalf of the participant and the parents/guardian.

Full Name: ______________________________________

Signature: ______________________________________ Date: ____________________

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Dear Health Care Provider:

Your patient is interested in participating at the Mane Stream. In order to safely provide services, our center requests you to complete the attached "Annual Medical History and Physician's Statement."

The Professional Association of Therapeutic Horsemanship International and the American Hippotherapy Association have written guidelines pertaining to precautions and contraindications for individuals participating in equine related activities. Therefore, when completing the "Annual Medical History and Physicians Statement," please note if these conditions are present and to what degree. The following is a list of suggested precautions and contraindications:

Orthopedic:
Atlantoaxial Instability
Coxa Arthrosis
Cranial Deficits
Heterotopic Ossification/Myositis
Ossoficans
Joint Subluxation/dislocation
Osteoporosis
Pathologic Fractures
Spinal Fusion/Fixation
Scoliosis
Spinal Instability/Abnormalities

Neurologic:
Hydrocephalus/Shunt
Seizure
Spina Bifida/Chiari II malformation/Tethered Cord/Hydromyelia

Other:
Age- under 2 years
Indwelling Catheters
Medications – i.e. photosensitivity
Poor endurance
Skin Breakdown

Medical/Psychological:
Allergies
Animal Abuse
Physical/Sexual/Emotional Abuse
Blood Pressure Control
Dangerous to self or others
Exacerbations of medical conditions
Fire Settings
Heart Conditions
Hemophilia
Medical Instability
Migraines
PVD
Respiratory Compromise
Recent Surgeries
Substance Abuse
Thought control disorders
Weight control disorder

Precautions and Contraindications

The primary focus of any facility offering equine related services is to provide a safe and productive experience for all participants. The question that must be asked is "Will the benefit outweigh the risk?" The general rule is "do no harm."

A precaution is defined as a measure taken beforehand against possible danger, failure, etc. Participants with precautions may require modifications to their program, additional equipment, and always require re-evaluations at regular intervals to assure the effectiveness of participation.

A contraindication is a condition or symptom that makes equine related services inappropriate. Few contraindications are clear-cut. A contraindication may be permanent; meaning some activities may never be appropriate for certain participants due to safety or health concerns. A contraindication may also be temporary until the participant's health or condition improves. A participant may also begin with equine related services as

part of their program, but may find it no longer safe to include equine movement with the progression of his or her disability.

The following must be considered when deciding to include equines:

Most equine related services inherently involve movement. If the movement will cause a decrease in the participant's function, an increase in pain, or generally aggravate the medical condition it may not be the intervention of choice.

The essence of equine related services is the human-animal connection. If this interaction is detrimental to the participant or the equine, services may be contraindicated.

Equine related services always presents the potential for a fall. Such a fall may cause a greater functional impairment than the participant originally had. The possibility of a fall should be given careful consideration and may lead to the informed decision.

Working around equines (i.e. grooming, leading, etc.) involves risk. Even the well-trained equine is subject to its instinctive fight or flight responses. Horses are large, move quickly, and can be dangerous to the participant who is unable to respond appropriately.

Atlantoaxial Instability in Down Syndrome as Related to Equine Related Services

Potential participants and parents of potential participants should be aware of the inherent risks involved with equine related services for individuals diagnosed with Down syndrome and/or atlantoaxial instability. Mane Stream is guided by the recommendations of PATH International, AHA Inc., and Special Olympics, all recognized experts in the area of activities for people with disabilities.

There is evidence that 10-20% of individuals with Down syndrome suffer from Atlantoaxial Instability. Atlantoaxial Instability can be defined as instability, subluxation or dislocation of the joint between the first and second cervical vertebrae (atlantoaxial joint). Instability of the joint is generally due to poor muscle tone and ligament laxity that is common with Down syndrome.

A lax joint may begin to put pressure on the spinal cord resulting in the following **neurologic symptoms**:

- Change of head control-head tilt, torticollis/wry neck, stiff neck
- Change of gait- progressive clumsiness, toe walking or scissoring, falling, posturing
- Change of hand control- progressive weakness, fisting, change of dominant hand, increasing tremor
- Change of bladder function
- Change of bowel function
- Increase in muscle tone
- Fatigue

Neurologic signs always supersede radiographs and can be considered a contraindication.
Atlantoaxial Instability exposes individuals with Down syndrome to the possibility of injury if they participate in any activity the hyper-extends, radically flexes, or creates direct pressure on the neck or upper spine. This condition can occur spontaneously or be induced by injury that results from excessive anterior movement of the upper spine.

Although every precaution is taken at Mane Stream to make services as safe and as risk free as possible, there is always risk involved when working around or sitting on a horse. Even the quietest of horses are by nature unpredictable, thereby increasing the possibility of an injury. A fall from a horse, a sudden movement of the horse, or even the horse's normal stride/movement can create hyper-extension or hyper-flexion of the neck and upper spine.

PATH International requires that all potential participants with Down syndrome have a medical examination by a licensed physician including a complete neurological exam that shows no evidence of AAI or neurologic symptoms. This information must be noted on the Annual Medical History and Physicians Statement. Thereafter an annual examination from a physician or qualified medical professional stating that the participant's physical exam reveals no signs of AAI or decrease in neurologic function is required for continued participation in any equine related services at Mane Stream.

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ANNUAL MEDICAL HISTORY and PHYSICIAN'S STATEMENT

Please have the following information completed by the participant's physician.
The physician's signature of consent is required. This information is kept confidential.

Participant's Information

Participant's name: ______________________________ Today's Date: ____________________
Address: ____
DOB: __________ Gender: M ____ F ____

Height: _______ **Weight**: ________ ***Physician's initials are required here*** ____________
It is crucial that this information be truthful and accurate. To provide inaccurate information may jeopardize the safety of the participant and others.

Medical Summary

Primary diagnosis: ________________________ Cause if known: ______________________
Other diagnoses: ____
If Down Syndrome/AAI- result of yearly neurological exam/test for AAI: ❑Negative ❑Positive
Results/date of exam/test: ______________________________________
Recent surgical procedures or hospitalization: ____
Brief current medical condition: ____
Date of last tetanus: __________

Current Medications

Name: __________________ Dose: __________ For treatment of: ____________________
Name: __________________ Dose: __________ For treatment of: ____________________
Name: __________________ Dose: __________ For treatment of: ____________________

Abilities

Assistive Aids (*please check all that currently apply to the client, or note history in space provided*):
_____ Orthotics/Splints/Prosthetics (*specify type*): ______________________________________
_____ Cervical collar/Abdominal binder/Other trunk supports (*specify type*): _______________________
_____ Wheelchair/Walker/Crutches (*specify type*): ______________________________________
_____ Other assistive aids: ____

Physical Skills (*please rate the following skills using the scale provided*):

(**0**) *Not able to perform skill that at this time*
(**1**) *Beginning Skill* *requires moderate assistance from others*
(**2**) *Moderate Ability* *requires minimal assistance from others*
(**3**) *Mastered* *is performed independently*

_____ Head and neck control ____
_____ Unsupported sitting balance ____
_____ Unsupported standing balance ____
_____ Unsupported walking ____
_____ Upper extremity (arm) strength / movement ______________________________
_____ Lower extremity (leg) strength / movement ______________________________
_____ Fine motor (hand/finger) strength / movement ____________________________
_____ Gross motor (whole body) coordination _________________________________

Cognitive Skills (*please rate the following skills using the scale provided*):

(**0**) *Not able to perform skill at this time*	(**1**) *Beginning Skill* requires moderate assistance from others	(**2**) *Moderate Ability* requires minimal assistance from others	(**3**) *Mastered* is performed independently

_____ Alertness/Attention ______________________________

_____ Ability to follow 1-step commands ______________________________

_____ Ability to follow multiple-step commands ______________________________

_____ Activity level / endurance ______________________________

_____ Visual ability ______________________________

_____ Expressive Language______________________________

_____ Language Comprehension ______________________________

_____ Socialization skills ______________________________

Precautions/Contraindications (*Please check all that currently apply to your patient and degree of involvement, or note history in space provided. Please note that the following conditions may be a contraindication to participation*):

_____ Allergies (*specify type*)______________________________

_____ Arthritis (*rheumatoid or osteo*) ______________________________

_____ Asthma ______________________________

_____ Atlanto-Axial Instability- positive X-ray or positive neurological exam______________________________

_____ Behaviors ______________________________

_____ Blood clots, deep vein thrombosis, peripheral vascular disease ______________________________

_____ Body temperature regulation problems ______________________________

_____ Bone abnormalities (*osteoporosis, pathologic fractures*) ______________________________

_____ Brain injury ______________________________

_____ Communicable Diseases ______________________________

_____ Contractures/limited ROM (*location*) ______________________________

_____ Gastro-intestinal or naso-gastric, or tracheal tube ______________________________

_____ Heart condition/abnormality ______________________________

_____ Hypertension ______________________________

_____ Joint/tendon laxity, subluxation, dislocation ______________________________

_____ In-dwelling catheter ______________________________

_____ Shunt ______________________________

_____ Psychiatric condition (*type*) ______________________________

_____ Respiratory complications (*type*) ______________________________

_____ Seizures (*list type, frequency and duration*) ______________________________

Date of last seizure: ______________________________

_____ Skin integrity issues, skin breakdown, skin/decubitus ulcers ______________________________

_____ Chiari II malformation, tethered cord (*include release date*) ______________________________

_____ Scoliosis ______________________________

Location & degree of curve: ______________________________

_____ Spinal fusion or internal fixators (*specify area, type, vertebrae involved*): ______________________________

_____ Other (*please specify*) ______________________________

Physician's Statement

In my capacity as medical advisor, I consent to the participation of ______________________________

Patient's full name

in the therapy services at Mane Stream. I certify that all of the information that I have given is accurate and represents a complete medical history.

Physician's name: ______________________________ **Date:** ____________________

Address or stamp:

Physician's signature: ______________________________