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 approximately 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
Director of Program Services
PATH Intl. Certified Advanced Instructor
jen@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 or instructor in training 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's name: _____ Preferred name: _____

Preferred Gender: ❑ M ❑ F ❑ Gender nonconforming ❑ Decline to answer

❑ Additional gender category (please specify): _____

Pronouns: _____ DOB: _____

Parent name: _____ Parent name: _____

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

Street: _____ Town: _____

State: _____ Zip: _____ County of Residence: _____

CONTACT INFORMATION

Contact Person	*Phone*	*Contact person*	*Phone*
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.

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

1) Contact: _____ Phone: _____ ❑ okay to text

2) Contact: _____ Phone: _____ ❑ 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: _____

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**

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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Mane Stream
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.

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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, Inc. 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

By providing this form to my or the participant's physician, I provide my consent for their disclosure of the information about the named participant required in this form to Mane Stream. 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 _____

ANNUAL MEDICAL HISTORY and PHYSICIAN'S STATEMENT

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 horseback riding program and/or 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: _____