CHAPS Equine Assisted Services
www.chapswyo.org

December 1, 2023

Dear Clients, Parents and Caregivers;

Here is your application for participation in adaptive riding, adaptive driving or equine assisted learning at CHAPS for the 2024 calendar year (Sessions beginning March 5 and ending November 16). Please note the following standards for participation:

- All clients must have a therapeutic goal for riding, and have the recommendation of a physician, therapist, educator, case worker, social worker, etc. to be considered.
- Completed applications must be received by:
  - February 13 for participation in sessions 1-4
  - April 9 for participation in sessions 2,3 & 4
  - June 25 for participation in sessions 3 & 4
  - September 3 for participation in session 4
- A financial aid application must be completed and returned with the participation application if a scholarship is needed to participate
- Scholarships are awarded on a first come, first served basis
  - Please refer to our financial aid application for fee schedule
  - Participation fee the first session MUST accompany your application

The staff at CHAPS is available to help you fill out your application – please call for an appointment. Applications will be accepted from January 2nd, 2024 forward. Any applications received before January 2nd, 2024 will not be considered for the 2024 season.

*CHAPS does not discriminate based on age, race, ethnicity, gender, sexual orientation, disability, religion, political affiliation, etc. Limitations are solely based on physician's recommendations & scholarship availability.

CHAPS Equine Assisted Services
Enclosures

CHAPS Equine Assisted Services

Client Application

Mailing Address:
PMB 201, 1590 Sugarland Dr. Ste. B
Sheridan, WY 82801
Phone: 307.673.6161 email: info@chapswyo.org

Client Name: _____

Parent/Guardian: _____

Referring agency: _____

Application Received On: ___/___/___ by whom (staff): _____

Required Information:

Client Name: _____

Prefers to be called: _____ DOB: ____/____/____

Home Address: _____

City: _____, State: _____ Zip: _____

Client's Email: _____

Client's Employer: _____

Home Phone: _____ Cell: _____

Are you or anyone in your immediate family a veteran of the armed forces of the United States of American? ◯YES/NO◯

Agency/School _____Telephone: (_____) _____-_____

Case Worker: _____Telephone: (____) ____-_____ Email: _____

Legal Guardian: _____Email: _____

Daytime Telephone: (_____) _____-_____ Evening Telephone: (_____) _____-_____

Address: _____

City: _____, State: _____ Zip: _____

Payee: _____Telephone: (_____) _____-_____

Address: _____

City _____, State: _____ Zip _____

T-Shirt size: _____

Goals and Objectives

Goals:

Therapeutic Goals (What are you working on in Physical/Occupational/Speech-Language Therapy or in Counseling?):

_____

_____

_____

_____

Leisure interests/hobbies:

_____

_____

_____

_____

Fears/Concerns:

_____

_____

_____

_____

_____

Objectives:

Why are you applying for equine assisted activities in 2024?

_____

_____

_____

_____

_____

What goals do you have for participating at CHAPS this year?

_____

_____

_____

_____

Name (PRINT CLEARLY): _____

Signature: _____ Date: ___/___/__

Adaptive Riding/Adaptive Driving/EAL PRE-Survey:

Client Name (PRINT CLEARLY): _____

1. Client's balance is (circle one): Poor ☐ Fair ☐ Good ☐ Excellent ☐
2. Client's posture is (circle one): Poor ☐ Fair ☐ Good ☐ Excellent ☐
3. Client can follow _____ directions at a time (circle one):
   1 ☐ 2 – 3 ☐ 3 – 4 ☐ 5+ ☐
4. Client's focus is (circle one): Poor ☐ Fair ☐ Good ☐ Excellent ☐
5. Client is _____ mobile (circle one): Somewhat ☐ Moderately ☐ Extremely ☐
6. How many times a week does the client express negative behaviors or tantrums (circle one)?
   0 ☐ 1 ☐ 2 – 3 ☐ 3 - 4 ☐ 5+ ☐
7. Client's social behaviors are (circle one): Poor ☐ Fair ☐ Good ☐ Excellent ☐
8. Client's ability to recognize and respect boundaries is (circle one):
   Poor ☐ Fair ☐ Good ☐ Excellent ☐
9. Please list the goals for this client:

_____

_____

_____

10. Please indicate how many weeks the client will participate at CHAPS (circle one):
    8 weeks ☐ 16 weeks ☐ 25 weeks ☐ 34 weeks ☐

Contract for Participation

CHAPS agrees to provide the following (select one):

1. One 30, 50-minute lesson per week for:
   8 weeks _____ or 16 weeks _____ or 24 weeks _____ or 33 weeks _____ **(please select one below)**
   i Riding _____
   ii Driving_____
   iii Equine Assisted Learning (ground) _____
   iv Mental health (ground) _____
   (Lesson length may be changed by the instructor based on application & client assessment)
2. A qualified, Professional Association for Therapeutic Horsemanship International (hereinafter referred to as 'PATH') Certified Professional or a Certified Horsemanship Association (here in referred to as "CHA") Certified Professional; with first aid and CPR training, carefully screened and trained equines, and certified volunteers to assist in lessons
3. A safe, appropriate facility built and maintained to ADA standards
4. 1 ASTM – SEI certified helmet for equestrian activity at CHAPS (a $50 value). Clients may leave helmets at CHAPS (recommended) but are responsible for replacing helmets that are taken home and lost or damaged
5. Upon request and with a signed consent for release of information form, CHAPS will share information with other members of the client's support team (progress notes, attend IEP or Plan of Care meetings, etc.)
6. Will provide a list of PATH precautions and contraindications for participation if requested
7. Will provide a copy of this contract and rules/guidelines for participation to each client and/or legal representative
8. A standing weekly lesson appointment for consistency, assigned on a first come, first served basis

I have read and understand: _____ (Client and/or legal representative initials)

Client agrees to provide the following:

1. Prompt transportation to and from the facility or off-site location for lessons and other activities
2. Supervision for clients should they arrive more than 5 minutes before the start of their lesson or activity
3. Appropriate clothing and footwear (please refer to CHAPS Rules)
4. Proper nourishment, medication, toileting, and rest prior to arriving and during time at CHAPS. Clients with bee/insect sting allergies must arrive with a current epi-pen and inform instructor of its whereabouts every time they come to CHAPS
5. Clients who are unable to toilet independently, have a seizure disorder, or cannot be left alone at any time ***must*** have a caregiver with them when they are at CHAPS. If the client uses the toilet, that caregiver must accompany them to the toilet to assure that it is used properly and left in clean condition
6. Advance notice of **no less than two hours prior** to lessons if they are unable to attend, failure of advance notice will result in a "no show" mark up and potential consequences
7. Updates/notification within one week of changes in medication, therapy, or treatments in writing from the client's legal representative for emergency responder information
8. Cancellation of lesson with as much notice as possible for clients feeling sick or showing symptoms of COVID-19

I have read and understand (Client and/or legal representative **initials**): _____

Client and legal representative further understand that:

1. A no-show occurs when the client does not show up for the scheduled lesson without 2 hours' notice, is excessively late, or is not prepared to participate. No makeup lesson will be provided, and the client forfeits the fees paid.
2. If a client is over 15 minutes late for a private lesson with or without notice, it may be counted as a no show at the discretion of the Instructor, or the client will have an abbreviated lesson at the same fee as usually charged for lessons. If the client is too late to participate, the lesson fee is forfeited by the client/legal representative.
3. If a client is late for a semi-private or group lesson without notice, and arrives after the lesson is in progress, the lesson may be counted as a no show, with lesson fees forfeited by client/legal representative. Lessons in progress in the arena ***will not*** be interrupted by a latecomer.
4. Client/legal representative agrees to return this application with a check or cash in the amount of the fee for participation (please refer to the sliding scale appearing on the financial aid application).
5. If a client is transported to CHAPS by a school district or agency, and that entity is closed on a day that the client is due to attend a lesson, it is the responsibility of that client or their support team to find alternative transportation or notify the Instructor if they are not coming. Not doing so will result in a 'no-show' and no make-up lesson will be provided.
6. More than 2 no-shows will result in probation for those on scholarships. After 3 no shows, a scholarship may be revoked. Notification of probation will be in writing and/or email to the client or legal representative.
7. Clients who miss (either as a cancellation or a no show) more than 3 lessons per session will be asked to re-consider their commitment to participation and may be asked to relinquish their scholarship.
8. Misrepresenting medical conditions to CHAPS staff may be grounds for termination of participation privileges.
9. Make up lessons will be offered at the Instructor's discretion.
10. All lessons will be held unless temperatures in the Indoor Arena exceed 95 degrees F or below 30 degrees F.

I have read and understand (Client and/or legal representative **initials**): _____

Lessons run 9am thru 5pm, Tuesday through Saturday, depending on availability. Please give us your 1st, 2nd, 3rd time/day preference:

1st: _____ 2nd: _____ 3rd: _____

The undersigned enter into this agreement as stated:

Client and/or legal guardian (signature): _____ Date: ___/___/___

Client and/or legal guardian name (PRINT CLEARLY): _____

CHAPS Representative (signature): _____Title: _____

CHAPS Representative (print name): _____Date: ____/____/____

Agreement of Confidentiality:

As a client at CHAPS, I agree to hold in strict confidence those names, all medical, social, referral, personnel and financial information regarding clients, staff, volunteers or any and all clients at CHAPS Equine Assisted Services at any time and in any capacity. I agree to the above stipulations regarding confidentiality, and furthermore understand that violating this agreement in any way may result in the termination of my association with CHAPS, and possible legal action.

Signature of Client (if appropriate): _____Date: ___/___/___

Signature of Parent and/or legal guardian: _____Date: ___/___/___

Photo Release:

Please check one and sign:

I Do: _____

I Do NOT: _____

Consent to and authorize the use and reproduction by CHAPS Equine Assisted Services of any and all photographs and any other audio-visual materials taken of me/my child/my ward for promotional material, educational activities, and exhibitions or for any other use for the benefit of the program.

Signed by Client: _____Date: ___/___/___

Signed by Legal Representative: _____Date: ___/___/___

Acknowledgement:

I understand that to remain a client at CHAPS Equine Assisted Services, I will be asked to follow the rules and guidelines of the organization. I have been given a copy of these rules and guidelines and will provide them to any and all persons involved in the transportation or supervision of this client.

I will attend lessons regularly, and if I leave the program for any reason, I will relinquish any claim to scholarship funding and return the helmet given to me by CHAPS.

I have read and understand the rules and guidelines and agree to abide by them.

Client Name (PRINT CLEARLY): _____

Client Signature (if appropriate): _____Date: ___/___/___

Legal Representative Name (PRINT CLEARLY): _____

Legal Representative Signature: _____ Date: ___/___/___

Application for Financial Assistance

All information gathered for the purpose of retaining scholarship funding for clients remains confidential

Notary witness and seal required – do not sign unless in the presence of a Notary

Scholarships for 34 weeks of lessons (March 5 – Nov 16, 2024) may be available on a first come, first served basis. The amount of scholarships available to award is not guaranteed and is based on what is donated to the program.

To qualify for financial aid: Please note the fee schedule has changed since we moved to 4 sessions.

- ***Clients or families of clients earning less than $45,000.00*** *(total household income)* per year are eligible for one $3,600.00 scholarship per year (awarded on a first come, first served basis), with a $10 co-pay per lesson.
- ***Clients or families of clients earning between $45,000.00 and $55,000.00*** *(total household income)* per year are eligible for a $2,790.00 scholarship per year, with a $25 co-pay per lesson.
- ***Clients or families of clients earning between $55,000.00 and $65,000.00*** *(total household income)* per year are eligible for one $1,980.00 scholarship per year, with a $55 co-pay per lesson.
- ***Clients or families of clients earning over $65,000.00*** *(total household income)* per year are not eligible for scholarships, and the participation fees are as follows, payable on a session basis – 4 sessions: $3630, 3 sessions: $2640, 2 sessions: $1740, 1 session: $990. * Rates may vary depending on sessions chosen.

A check in the correct amount must accompany this application.

Client's Name: _____

Form completed by: Client _____ Parent _____ Guardian _____ Payee _____

If not a Client, please complete the rest of this form

Name: _____ Telephone: _____ Email: _____

Address: _____ City: _____ State: ___ Zip: _____

Client____ or Parent's____ (check one) yearly income: _____

Source of income:

Employer: _____ Address: _____

Supervisor: _____ Telephone: _____

Federal Assistance: _____ Yearly Amount: _____

State Assistance: _____ Yearly Amount: _____

Additional Support/Assistance: _____ Yearly Amount: _____

I attest that the preceding information is current and true to the best of my knowledge.

Signature: _____Date: ____/____/____

Name (PRINT CLEARLY): _____

Notary Signature and Seal required:

X_____

Authorization for Emergency Medical Treatment

Client's Name: _____DOB: ___/___/___

Physician's Name: _____ Physician's Phone Number: _____

Preferred Medical Facility: _____

Health Insurance Company: _____ Policy #: _____

Allergies to medications: _____

Current medications (including over-the-counter medications): _____

_____

Emergency Contact: _____

Relationship to Client: _____ Phone: _____

Emergency Contact: _____

Relationship to Client: _____ Phone: _____

In the event that emergency medical aid/treatment is required due to injury or illness during the process of receiving services, or while being on the property of CHAPS, I authorize CHAPS Equine Assisted Services staff 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 treatment

Please check and complete one of the following plans:

_____**Consent Plan:**

This authorization includes X-ray, surgery, hospitalization, medication and any treatment procedure deemed 'life saving' by the physician. This provision will be invoked only if the person(s) above is unable to be contacted.

Date: ___/___/___

Consent Signature: _____ Relation to Client: _____

Witness: _____ Date: ____/____/____

OR

_____**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 CHAPS Equine Assisted Services. I agree to have a parent or legal guardian remain on site at all times during equine assisted activities and therapeutic riding lessons. In the event that emergency treatment/aid is required, I wish the following procedure to take place:

_____

_____

Consent Signature: _____ Relation to client: _____

Witness: _____ Date: ___/___/___

CHAPS Equine Assisted Services

General Liability Release

The undersigned is aware that all activities involving horses including but not limited to riding, driving, grooming, leading or events involving horses pose many inherent dangers, risks and hazards including but not limited to bodily injury and physical harm to rider, groomer, leader, handler, side walker, photographer, spectator and/or helper. I (the undersigned) freely and fully assume all such risks, dangers, and hazards and the possibility of injury, death, property damage or loss resulting from such risks, dangers, and hazards.

I hereby agree as follows (please initial each line):

_____1) To assume and accept all risks, dangers, and hazards in connection with my use or my minor child's or ward's use of the facilities at CHAPS or any off-site activities sponsored by CHAPS

_____2) To waive any and all claims that I may have against CHAPS and the property owners as a result of my, my minor child or ward's use of the facility or participation in any off-site activity sponsored by CHAPS

_____3) To release CHAPS, it's employees, board of director members, volunteers, spectators, clients, property owners and all people involved with CHAPS from any and all liability, rights of action, or causes of action arising out of contract, tort or otherwise for any loss, damage, injury or expense that I, my minor child or ward, next of kin of myself, my minor child or ward, may suffer or incur as a result of use of the facilities or participation in off-site activities sponsored by CHAPS due to any cause whatsoever

_____4) The undersigned agrees to hold harmless and indemnify CHAPS, and any employees, volunteers, board of director members, spectators, clients and or property owners from any and all liability for personal injury, property damage or death suffered by myself, my minor child or ward or by a third party as a result of use of and/or presence at the facility or off-site activities sponsored by CHAPS

_____5) That, in the event of my, my minor child or ward's injury or death, this release and indemnity agreement shall be effective and binding upon mine and my minor child or ward's heirs, next of kin, executors, administrators and assigns in relation to CHAPS, it's property owners and any and all people involved.

Client:

I acknowledge that I have read and understood this release and indemnity. I am at least 18 years of age and am aware that by signing this document, I am affecting legal rights and liabilities of myself, my heirs, next of kin, executors, administrators, and assigns in relation to CHAPS, its property owners and any and all people involved.

Name (PRINT CLEARLY): _____ Date: ___/___/___

Signature: _____

Witness: _____

Guardian or Legal Representation of a Minor or ward:

I acknowledge that I have read and understood this release and indemnity. I am 18 years of age or older. I have the authority as the parent or legal guardian of (please **print legibly**) _____ to sign and release on behalf of the minor/ward so that the minor/ward may participate and use the facilities offered by CHAPS. I am aware that by signing this document, I am affecting legal rights and liabilities of the minor/ward, his/her heirs, next of kin, executors, administrators, and assigns in relation to CHAPS, its property owners and any and all people involved.

Name (PRINT CLEARLY): _____ Date ___/___/___

Signature: _____

Witness: _____

CHAPS Equine Assisted Services

COVID-19/Infectious Disease Liability Release

By signing below, I _____ (**print** name) on behalf of _____ (name of ward/minor child(ren), if applicable), hereby acknowledge that I have received a copy of CHAPS's COVID-19 Operating Procedures. I further acknowledge that while CHAPS is following the measures set forth in its Operating Procedures, due to the contagious nature of COVID-19 and other infectious diseases, CHAPS cannot guarantee that a client of CHAPS will not be exposed and/or infected and participation in CHAPS's programs may increase the risk of a client in contracting COVID-19 or other infectious diseases, which may result in personal injury, illness, permanent disability, and death. I understand that the risk of becoming exposed to or infected at CHAPS may result from the actions, omissions, or negligence of myself (or my ward/minor child(ren)) and others, including, but not limited to, CHAPS employees, volunteers, program clients and their families.

In understanding these risks, I agree to assume all of the foregoing risks and accept sole responsibility for any injury to my ward, or my child(ren) or myself (including, but not limited to, personal injury, disability, and death), illness, damage loss, claim, liability, or expense of any kind, that I or my child(ren), or my ward, may experience or incur in connection with my/my child(ren)'s/my ward's participation in the CHAPS programs ("Claims"). On my behalf, or on behalf of my child(ren)/ward, I hereby release, and covenant not to sue, discharge, and hold harmless CHAPS, its employees, agents, board of directors, and representative of and from the Claims, including all liabilities, claims, actions, damages, costs or expenses of any kind arising out of or relating thereto. I understand and agree that this release includes any Claims based on the actions, omissions, or negligence of CHAPS, its employees, agents, board of directors, and representatives, whether a COVID-19 or other infection disease infection occurs before, during or after participation in any CHAPS program.

Client:

I acknowledge that I have read and understood this release and indemnity. I am at least 18 years of age and am aware that by signing this document, I am affecting legal rights and liabilities of myself, my heirs, next of kin, executors, administrators, and assigns in relation to CHAPS, its employees, agents, board of directors, and representatives.

Name (PRINT CLEARLY): _____ Date: ___/___/___

Signature: _____

Witness: _____

Guardian or Legal Representation of a Minor or ward:

I acknowledge that I have read and understood this release and indemnity. I am 18 years of age or older. I have the authority as the parent or legal guardian of (please print legibly) _____ to sign and release on behalf of the minor/ward so that the minor/ward may participate and use the facilities offered by CHAPS. I am aware that by signing this document, I am affecting legal rights and liabilities of the minor/ward, his/her heirs, next of kin, executors, administrators, and assigns in relation to CHAPS, its employees, agents, board of directors, and representatives.

Name (PRINT CLEARLY): _____ Date ___/___/___

Signature: _____

Witness: _____

Client Medical History

Please check any of the following that apply:

☐ Lack of Concentration	☐ Learning Disabilities	☐ Developmental Delay	☐ Mentally Challenged
☐ Hyperactivity	☐ Self-Injurious Behavior	☐ Tics/stereotypic Behavior	☐ Sensitivity, preferences
☐ Anxiety	☐ Phobias	☐ Aggressive	☐ Assaultive
☐ Sensory issues	☐ Unpredictable/Dangerous	☐ Psychosomatic Symptoms	☐ Manipulative
☐ Sexual Abuse	☐ History of Physical abuse	☐ History of emotional abuse	☐ Other (please explain on back of page)

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

Special Needs:	Yes	No	Describe:
Auditory			
Visual			
Tactile Sensation			
Speech			
Cardiac			
Circulatory			
Integumentary/Skin			
Digestion			
Elimination			
Immunity			
Pulmonary			
Neurologic			
Muscular			
Balance			
Orthopedic			
Allergies			
Learning Disability			
Cognitive			
Emotional/Psychological			
Behavioral			
Pain			
Other			

Describe mobility; i.e. independent ambulation, assisted ambulation, wheelchair, braces, etc.

_____

To the best of my knowledge, the medical history is true and accurate:

Client Signature: _____ Date: ___/___/___

Legal Guardian Signature: _____ Date ___/___/___

Client's Medical History and Physicians Statement

December 1, 2023

Dear Health Care Provider.
Your patient, _____, is interested in participating in supervised equine assisted activities at CHAPS Equine Assisted Services. In order to safely provide this service, we request that you complete/update the attached Medical History and Physician's Statement Forms. Please note that the following conditions may suggest precautions and contraindications to participating. Therefore, when completing these forms, please note whether these conditions are present, and to what degree:

Client Name: _____

DOB: _____/_____/_____ **Height**: _____ft _____in. **Weight**: _____lbs.

Diagnosis:

1. _____
   Date of onset: _____/_____/_____
2. _____

   Date of onset: _____/_____/_____ (*If more room is needed, please use a separate page)*

Past/prospective surgeries:

1. _____
   Date: _____/_____/_____
2. _____

   Date: _____/_____/_____ (*If more room is needed, please use a separate page)*

Medications:
_____

Possible Medication Side Effects:
_____

Seizure Type: _____ Controlled? Y ☐ N ☐

Date of last Seizure: _____/_____/_____

Shunt: Y ☐ N ☐ Date of last revision: _____/_____/_____

Indwelling Catheter/Medical Equipment: Y ☐ N ☐
Describe:
_____

Braces/Assistive Devices: Y ___ N ___
Describe: _____
May they be used while participating in Therapeutic Riding and Equine Assisted Activities?
Y ☐ N ☐

Physician's Signature & Statement

Given the above diagnosis and medical information, this person is not medically precluded from participation in equine assisted activities and therapeutic riding. I understand that CHAPS Equine Assisted Services is a PATH International Center and will weigh the information given against existing precautions and contraindications as noted by PATH International. Therefore, I refer this person to CHAPS Equine Assisted Services for ongoing evaluation to determine eligibility for participation.

Name/Title: _____MD DO NP PA

Other: _____

Signature: _____

Name (print): _____ Date: ___/___/___

Address: _____

Telephone: (____) _____ Fax: (____) _____
License/ UPIN Number: _____

For those with Down syndrome:

Neuro exam to determine atlantoaxial instability

Date performed: ____/____/_____

Positive _____ Negative _____

HIPAA Notice of Privacy Practices Statement

Notice of Information Practices and Privacy Statement for CHAPS Equine Assisted Services

How We Collect Information About You: CHAPS Equine Assisted Services and its employees and volunteers collect data through a variety of means including but not necessarily limited to letters, phone calls, emails, voice mails, and from the submission of applications that is either required by law, or necessary to process applications or other requests for assistance through our organization.

What We Do Not Do with Your Information: Information about your financial situation and medical conditions and care that you provide to us in writing, via email, on the phone (including information left on voice mails), contained in or attached to applications, or directly or indirectly given to us, is held in strictest confidence. All sensitive information is kept in a locked filing cabinet until destroyed.

We do not give out, exchange, barter, rent, sell, lend, or disseminate any information about applicants or clients who apply for or actually receive our services that is considered patient confidential, is restricted by law, or has been specifically restricted by a patient/client in a signed HIPAA consent form.

How We Do Use Your Information: Information is only used as is reasonably necessary to process your application or to provide you with health or counseling services which may require communication between CHAPS and health care providers, medical product or service providers, pharmacies, insurance companies, and other providers necessary to: verify your medical information is accurate; determine the type of medical supplies or any health care services you need including, but not limited to; or to obtain or purchase any type of medical supplies, devices, medications, insurance,

If you apply or attempt to apply to receive assistance through us and provide information with the intent or purpose of fraud or that results in either an actual crime of fraud for any reason including willful or un-willful acts of negligence whether intended or not, or in any way demonstrates or indicates attempted fraud, your non-medical information can be given to legal authorities including police, investigators, courts, and/or attorneys or other legal professionals, as well as any other information as permitted by law.

Limited Right to Use Non-Identifying Personal Information from Biographies, Letters, Notes, and Other Sources: Any pictures, stories, letters, biographies, correspondence, or thank you notes sent to us become the exclusive property of CHAPS. We reserve the right to use non-identifying information about our clients (those who receive services or goods from or through us) for fundraising and promotional purposes that are directly related to our mission.

Clients will not be compensated for use of this information and no identifying information (photos, addresses, phone numbers, contact information, last names or uniquely identifiable names) will be used without client's express advance permission.

You may specifically request that NO information be used whatsoever for promotional purposes, but you must identify any requested restrictions in writing. We respect your right to privacy and assure you no identifying information or photos that you send to us will ever be publicly used without your direct or indirect consent.

Name (PRINT CLEARLY): _____

Signature: _____ Date: _____/_____/_____

December 1, 2023

Dear Mental Health Care Professional.

Your patient, _____, is interested in participating in equine assisted activities at CHAPS Equine Assisted Services. In order to safely provide this service, we request that you complete/update the attached Mental Health Data. Please note that the following conditions may suggest precautions and contraindications to participating. Therefore, when completing these forms, please note whether these conditions are present, and to what degree:

Medical/Psychological

___ Aggressive	___ Allergies	___ Animal Abuse	___ Anxiety
___ Assaultive	___ Abuse: Physical, Sexual or Emotional	___ Dangerous to Self or Others	___ Delusional
___ Dissociations	___ Fire Setting	___ Hallucinations	___ History of running away
___ Parental or Familial Support Issues	___ Legal/School/ Employment Problems	___ Manipulative	___ Migraines
___ Phobias	___ Recent Hospitalizations	___ Social Skill Problems	___ Substance Abuse
___ Thought Control Disorders	___ Unpredictable or Dangerous Behavior	___ Weight Control Disorders	___ Medications, i.e. photosensitivity

Thank you in advance for your assistance. If you have any questions or concerns about this patient's participation in equine assisted activities, please contact the center at the address, phone or email below. Your assistance in providing correct, updated medical information about our shared client is ***essential*** to our staff to provide safe, appropriate lesson plans that will avoid exacerbating medical and psychological conditions.

CHAPS Equine Assisted Services
PMB 201, 1590 Sugarland Dr, Ste B
Sheridan, WY 82801
307-673-6161
info@chapswyo.org

Sincerely,

CHAPS Equine Assisted Services

Mental Health Data Form

Client's Name: _____Age: _____ DOB: ___/___/___

Parent/Legal Guardian or Representative: _____

Home Phone: _____ Cell Phone: _____

Address: _____

Physician: _____

Therapist: _____Title: _____

Phone: _____

Address: _____

Fax Number: _____ Email: _____

Diagnosis (DSM-V)

Axis I: _____

Axis II: _____

Axis III: _____

Axis IV: _____

Axis V: _____

Presenting Problems

_____

_____

_____

_____

Current Medications

Drug	Dose	Route	Time	Diagnosis

Psychiatric Treatment History

Current History including date and location of current diagnosis:

_____

_____

_____

_____

Outpatient History:

_____

_____

_____

_____

Inpatient Therapy:

_____

_____

_____

_____

Signature: _____

Name, Title (print): _____

Address: _____

Telephone: _____Fax: _____Email: _____

The rest of this page is intentionally left blank

CHAPS Equine Assisted Services Standards and Guidelines – Clients should keep this section

Dress Code:

1. Footwear: Hard soled shoes or boots with a low heel are preferred for therapeutic riding. Sneakers may be used for driving, and boots or footwear that will protect feet from cold; heat, water, and injury are needed for other equine assisted activities. Please ask your instructor if you are unsure if your footwear is appropriate.
2. Long pants: no shorts, skorts, culottes, carpi pants or dresses/skirts. Riding breeches, form fitting jeans or tights are acceptable.
3. Socks: tube socks that will stay up under the knee are recommended for comfort and safety.
4. Shirts: should have at least a cap sleeve to protect shoulders, and kept tucked in or be form fitting.
5. Please dress appropriately for winter weather, in form fitting coats that do not hang below the hips or are loose so that they cannot get caught on a saddle horn when dismounting.
6. Jewelry: no jewelry that can get caught in manes or tails ('dangling' earrings, necklaces, rings/bracelets, etc.).
7. Electronic equipment: Cell phones, iPods, Walkman or any other personal electronic devices are not allowed the riding areas. Clients who arrive with electronic devices will be asked to leave them in the car or instructor's office during lesson. Family members or client's guests who are watching the lesson must turn off ringers or sounds for any electronic equipment they have on their person.
8. Helmets are provided by CHAPS and must be worn at all times by clients when in the barn or arena or when mounted on a horse or the Equicizer or when in a driving cart.

General barn etiquette, procedures and safety rules:

1. All clients must have an annually updated and fully completed application to participate.
2. No running, screaming or boisterous behavior on the property. Clients must be able to monitor their own behavior appropriately *or have a caregiver with them for supervision.*
3. Client's pets are not allowed at CHAPS, other than service dogs (if service dogs are present, there must be someone to supervise the dog while the client is working around the horses).
4. There is client and drop off parking in front of the barn for ambulatory and handicap-equipped vehicles. Please do not park in the parking lot in front of the green house or on the side of the green house.
5. Please do not hand feed horses or reach through the bars of the stalls to pet them.
6. Please supervise children at all times when they are not under the direction of their Instructor. Please do not allow children who are not participating in the lesson to distract clients with loud or unruly behavior.
7. All equipment areas and off-limits areas are labeled or located on one of several maps located around CHAPS. Please do not visit the houses or other off limit areas at the facility.
8. No unattended children or dependent adults in the rest room.
9. Clients who cannot sit unattended in the event that transportation picking them up is late or if typical behaviors may lead to them being asked to leave the class *must have a caregiver present.*
10. **Clients are asked to wait in their car** until the Instructor comes to the door to invite them in, particularly if there are horses in the aisle or if no one is available to supervise them. They may sit with a caregiver in the Memory Garden while waiting for the Instructor to start the lesson if the aisle is clear when they arrive.
11. Clients are not to open stall doors, handle horses or work with a volunteer unless the Instructor is present.

12. Clients are under the direction of their Instructor during the lesson. Any client that willfully disobeys an Instructor's direction may be asked to dismount or stop participating in the activity and wait outside the arena for the lesson to conclude. If you have suggestions for the Instructor, please wait until after the lesson – your input is very important to the instruction staff but may be distracting during the lesson.
13. Please feel free to observe a lesson with your child or client – however, please do not distract them by speaking to them or attracting their attention once the lesson has begun, for safety purposes.
14. CHAPS certified Volunteers are provided for lesson assistance.
15. Clients who arrive with medication to take or use (epi-pen, for example) must let the Instructor know where it is upon arrival.
16. Clients or caregivers who arrive at CHAPS under the influence of alcohol or illegal drugs, or who bring weapons to CHAPS will be asked to leave immediately, and their association with CHAPS may be terminated.

Make Up Lessons and Weather Conditions

1. Lessons will be held unless temperatures in the Indoor Arena exceed 95 degrees F or below 30 degrees F
2. Make up lessons may be offered (but are not guaranteed) at the discretion of the Instructor and as the schedule allows