

HighHopes

Therapeutic Riding

HORSES AND HUMANS
IMPROVING LIVES

Sensory Integration and Autism Workshop

February 10, 2018



High Hopes is...

A PATH Intl. Premier
Accredited Center

Accredited by the Certified
Horsemanship Association

Internationally renowned
for training & education

We offer...

Lectures by qualified
professionals with in-depth
experience.

Networking opportunities

A dynamic learning
environment

This workshop is ideal for all therapeutic riding professionals seeking an interactive, hands-on educational experience to further their understanding of Autism and Sensory Processing Issues in the TR setting. You will be led by Donna Latella, an occupational therapist and PATH Certified therapeutic riding instructor and Leslie Bridges-Parent, Pediatric Occupational Therapist.

- ◇ *Increase your awareness of Autism and Sensory Processing considerations in equine assisted activities.*
- ◇ *Enhance your instructor tool box with new therapeutic riding techniques specialized for participants with autism and sensory processing needs.*
- ◇ *Further understand the impact of Autism on participants' perspective and ability to adapt to the TR environment.*

PATH Int'l approved CEU's = 7 DE



For more information, contact
Sarah Carlson,
Special Program Manager
at (860) 434-1974 ext. 115 or
scarlson@highhopestr.org
Visit us online at www.highhopestr.org



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To register for a workshop, please complete the information requested below and send it together with the required fee* to:

High Hopes Therapeutic Riding, Inc.
36 Town Woods Road, Old Lyme, CT 06371
www.highhopestr.org
Fax: (860) 434-3723

Upon receipt of this completed form and payment, High Hopes will send you an official letter of welcome and any additional materials necessary.

For questions contact Sarah Carlson at (860) 434-1974 ext. 115, or scarlson@highhopestr.org.

Name: _____ Phone: _____

E-mail: _____ PATH Member # _____

Address: _____

City: _____ State: _____ Zip: _____

Organization or Program Affiliation: _____

Please register me for the following:

◇ Sensory Processing and Autism: February 10, 2018 _____ \$125 (Registration includes light lunch)

Registration Deadline: January 25, 2018

Reimbursement policy: Cancellations prior to the registration deadline will receive a refund minus a \$75 service fee.
No reimbursements will be granted after the registration deadline.



**HIGH HOPES THERAPEUTIC RIDING INC
REGISTRATION & RELEASE**

VISITOR & SPECIALTY VOLUNTEER FORM

PLEASE COMPLETE ENTIRE FORM

Please Check One: Visitor: ___ **Brd/Cmt Member:** ___ **Spec Event Volunteer:** ___ **One Day Vol/Group:** _____

Name: _____ Home #: _____ Cell #: _____ DOB: _____

Address: _____ Town: _____ zip _____

Email: _____

In case of Emergency, contact: (Parent if minor) _____ Phone: _____

Please indicate any medical conditions or medications we should be aware of in the event of an emergency: _____

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT: In the event emergency medical aid/treatment is required due to illness or injury while being on the property of the agency, I authorize High Hopes to: Secure and retain medical treatment and transportation, if needed and release records upon request to the authorized individual or agency involved in the medical emergency treatment.

Date: _____ **Consent Signature:** _____

If volunteer is under 18 years of age, both parent & volunteer/visitor signatures are required.

CONSENT PLAN (to be invoked in the event that your Emergency Contact cannot be reached) I give consent for emergency medical treatment/aid (including x-ray, surgery, hospitalization, medication, and any treatment procedure deemed "life saving" by the physician) in the event of illness or injury while on the property of the agency.

Date: _____ **Consent Signature:** _____

If volunteer is under 18 years of age, both parent & volunteer/visitor signatures are required.

***If you choose non-consent for emergency medical treatment/aid in the event of illness or injury while on the property of the agency, please request a Non-Consent Form, which requires notarization.**

PHOTO RELEASE:

_____ I hereby consent and authorize _____ I do not consent to, nor do I authorize. 1) High Hopes Therapeutic Riding, Inc. to use my(my child's) photograph or image in its print, online and video publications; 2) release High Hopes Therapeutic Riding, Inc., its employees and any outside third parties from all liabilities or claims that I might assert in connection with the above-described activities and 3) waive any right to inspect, approve or receive compensation for any materials or communications, including photographs, videotapes, DVDs, website images or written materials, incorporating photos/images of me(my child).

Date: _____ **Consent Signature:** _____

If volunteer is under 18 years of age, both parent & volunteer/visitor signatures are required.

CONFIDENTIALITY POLICY: At High Hopes, we place great importance on protecting the confidential information of our clients, our staff and our volunteers. "Confidential Information" includes, but is not limited to, personally identifiable information such as surnames, telephone numbers, addresses, e-mails, etc., as well as the non-public business records of High Hopes. In particular, medical information about clients, and information about their disabilities or special needs, must be protected as Confidential Information. Volunteers shall never disclose confidential information to anyone other than High Hopes staff. Volunteers must seek staff permission before taking any pictures or videos. I have read and understand High Hopes Confidentiality Policy and agree to abide by same.

Date: _____ **Signature:** _____

If volunteer is under 18 years of age, both parent & volunteer/visitor signatures are required.

LIABILITY RELEASE: I acknowledge the risks and potential for risks of horseback riding and related equine activities including grievous bodily harm. However, I feel that the possible benefits to myself are greater than the risks assumed. I hereby, intending to be legally bound for myself, my heirs and assigns, executors or administrators, waive and release forever all claims for damages against High Hopes Therapeutic Riding Inc., its Board of Trustees, Instructors, Therapists, Aides, Volunteers, and/or Employees for any and all injuries and/or losses I may sustain while participating as a High Hopes volunteer from whatever cause, including but not limited to the negligence of these related parties.

The undersigned acknowledges that he/she has read this Volunteer Application in its entirety; that he/she understands the terms of this release and has signed this release voluntarily and with full knowledge of the effects thereof.

Date: _____ **Signature:** _____

If volunteer is under 18 years of age, both parent & volunteer/visitor signatures are required.