Sensory Integration and Autism Workshop  
February 6, 2016

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.

For more information, contact Patti Coyle, Training & Education Director at (860) 434-1974 ext. 124 or pcoyle@highhopestr.org
Visit us online at www.highhopestr.org
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 Patti Coyle at (860) 434-1974 ext. 124, or pcoyle@highhopestr.org.

NAME_______________________________________________________________________________
ADDRESS _____________________________________________CITY_____________
STATE _____________________________________          ZIP   _________________
EMAIL:___________________________
PHONE (DAY)  ________________________PHONE (CELL) __________________________________

Please register me for the following:
◊ Sensory Processing and Autism: February 6, 2016  ______ $110 (Registration includes light lunch)

Registration Deadline: January 22, 2016
*Payment must be in the form of cash or check. Checks should be made payable to: High Hopes Therapeutic Riding, Inc. Cancellations prior to the registration deadline will receive a full refund minus a $50 service fee. No reimbursements will be granted after the registration deadline.
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.

### 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.

Shared/Forms/Volunteer /visitor & specialty volunteer reg form 10-11