HighHopes
Therapeutic Riding
HORSES AND HUMANS IMPROVING LIVES

# Therapy Horse Workshop

March 13, 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

*Equine selection and training are central to the success of our therapeutic horsemanship programs. Join our staff in a conversation about finding the right equine for your program's needs, training them for their unique roles and maintaining their well-being to ensure longevity in your herd.*

Topics include:

- Recruiting and selecting the right horses for your program
- Planning a trial period
- Tailored training systems to create willing partners
- Stress control: management techniques for happy horses
- Life beyond the TR Center

*Perfect for:*

- Equine Managers
- Program Directors
- Therapeutic Riding Instructors
- Equine Specialists
- And more….

PATH Int'l approved CEU's = 7CE

## Workshop Faculty

***Holly Sundmacker***, *High Hopes Equine Operations Director*

For more information, contact Sarah Carlson, Special Programs Manager at (860) 434-1974 ext. 115 or scarlson@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:**

◊ **Therapy Horse March 13, 2018** ______ **$175** (Registration includes light lunch)

**Registration Deadline: February 19, 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.*