

# HighHopes

## Therapeutic Riding

HORSES AND HUMANS  
IMPROVING LIVES

### High Hopes Advanced Preparatory Workshop February 5-7, 2018



#### High Hopes is...

*A PATH Intl. Premier  
Accredited Center*

*Internationally renowned  
for training & education*

*501c3 Non Profit Center*

*Four Star Charity  
through Charity  
Navigator*

#### We offer...

*Lectures by experienced  
professionals*

*Networking opportunities*

*A dynamic learning  
environment*

This 3-day workshop will focus on providing a comprehensive review of PATH Intl. Advanced Instructor Criteria and will explore all aspects of the Criteria through classroom discussion, hands on learning, and teaching opportunities with current High Hopes participants. This workshop will include many opportunities for discussion and candidate evaluation.

#### ***Who should attend?***

- Instructors seeking professional development
- Those planning to attend an Advanced Certification in the next two years
- Anyone wishing to hone their teaching skills

#### ***Topics to be covered in the Workshop include:***

- Cognitive and Physical disabilities
- Able-Bodied teaching
- Personal riding skills through participation in a lesson
- Group Instruction to individuals with disabilities
- Lesson planning for diverse groups
- Advanced mounting and dismounting techniques
- Lungeing techniques



#### ***Prerequisites:***

- Participants must be PATH Intl. Registered Instructors with over 75 hours of instruction.
- Participants must be secure riders at walk, trot and canter

***Limited Availability to 6 participants***

**PATH Int'l approved CEU's = 10 Riding CR; 5 DE; 6CE**



For more information, contact:  
Sarah Carlson, Special Programs Manager  
at (860) 434-1974 ext. 115 or [scarlson@highhopestr.org](mailto:scarlson@highhopestr.org)  
Visit us online at [www.highhopestr.org](http://www.highhopestr.org)

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## Therapeutic Riding

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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](mailto:scarlson@highhopestr.org).

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

E-mail: \_\_\_\_\_ PATH Member # \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Organization or Program Affiliation: \_\_\_\_\_

HEIGHT: \_\_\_\_\_ \*WEIGHT: \_\_\_\_\_ PREFERRED RIDING DISCIPLINE: \_\_ENGLISH \_\_WESTERN

\* Please note High Hopes horses have a weight limit of 180 lbs

Please register me for the following:

Advanced Prep Workshop \_\_\_\_ \$650.00

Registration Deadline: January 2, 2018

**Reimbursement policy:** Cancellations prior to the registration deadline will receive a full refund minus a \$150 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.*