Kidz in Motion - For Clinicians and Other Participants August 10-14, 2020

OT For Kidz is now welcoming back their 1 week (5 day) summer program. This program combines an exciting "camp-like" environment with an intensive sensory integration treatment approach for children ages 4-11 with special needs. Children participate in a broad range of fun-filled activities designed to have a therapeutic benefit. This is combined with occupational therapy utilizing the sensory integration theory and other neuro-behavioral strategies with the underlying understanding of plasticity of the brain. A limited number of applicants who are interested in participating will have the opportunity to experience hands-on learning using many dynamic strategies for working with children with special needs. Practical hands-on learning time combined with formal learning time together average 8 hours per day in additional to orientation training. Participants who are Occupational therapists and occupational therapy assistants will be eligible to receive 41 contact hours/.41 AOTA CEUs, other clinicians or educators 41 contact hours and students 41 volunteer hours. *NYSOTA Approved CE workshop* NYSOTA New York State Occupational Therapy Association

Orientation/Training Date: 8/8/20 RATE: Clinicians/Professionals Early Bird Rate $199/ Regular Rate $249; Students Free

Target Participants for Counselors: OT, COTA, PT, PTA, Speech Therapists, Teachers, other Pediatric Clinicians and Educators
Educational Level: Beginners-Advanced
Target Participants for Counselor Assistants: College Students in the field of Healthcare and/or Education

Learning Objectives:

1. Identify and demonstrate administering at least 1 standardized tool, through hands-on practical (BOT2)
2. Identify various sensory-based methods and strategies that may be used with children with special needs with diagnosis such as SPD, ASD, ADHD, LD and DD
3. Identify and differentiate between deficits in sensory processing affecting children's functional skills
4. Identify how to integrate sensory integrative concepts into a treatment protocol for children such a w/SPD, ASD, ADHD, LD, DD
5. Identify, List and demonstrate supportive strategies that may be used in your treatment regime

Most of the children may have mild to moderate learning disabilities, sensory processing disorders, ASD, ADHD and/or other developmental disorders that may be impacting their learning, ability to focus, motor, communication and/or social skills. All children will be ambulatory and toilet trained between the ages of 4-11. Participants will be able to work hands-on with the children. Each participant will be presented with opportunities to enhance professional development and skills within the framework of the child's goals and the mission of Kidz in Motion. **Our Mission** is to provide a treatment environment in the context of a fun filled "camp-like" experience to children with special needs. Participants will be assigned children with a ratio of 1:1 or 1:2 depending on the child. The participants along with OT For Kidz staff will collaborate to plan appropriate activities for each child and ways to make the child's experience a positive and therapeutic one. The daily regime consists of facilitating various structured sensory-based activities which will take place on-site at OT For Kidz as well as off-site. On-site activities include brain based exercises/activities (i.e. iLs, SMART, therapeutic massage,etc) and off-site activities include (therapeutic horse riding, aquatic activities, bounce house activity) to improve children's cognitive, social and/or motor skills. Breakfast & lunch will be provided daily for the participants.

Participants learning experiences will be facilitated by Paula Stewart, MS,OTR/L and Christine Grant, MS, OTR/L who are also the owners of OT For Kidz. Both Paula and Christine are both occupational therapist with over 20 years of clinical experience. They are SIPT certified clinicians which is an advanced national certification in the evaluation and treatment of Sensory Processing Disorders (SPD). Both have been trained in treating auditory processing deficits (usually part of a greater sensory processing disorder) using iLs (Interactive Listening Systems), IM (Interactive Metronome) or the Therapeutic Listening Program. They incorporate their training in Reflex Integration, Therapeutic Handling & Massage, neuronet and Oculo-motor/functional vision along with many other strategies into their treatment sessions and these are integrated into the Kidz in Motion Program.

If interested please contact us at: 718-949-5439 (office) 646-302-6709 (Paula) 917-478-7388 (Christine)
or email us at www.Occupationaltherapy4kidz@gmail.com Visit www.occupationaltherapy4kidz.com

KIDZ IN MOTION

REGISTRATION APPLICATION

NAME (PLEASE PRINT) : _____

HOME ADDRESS: _____

CONTACT NUMBER: _____

EMAIL ADDRESS: _____

POSITION (must be a licensed/registered clinician): ☐**OT/Counselor** ☐**COTA/Counselor** ☐**ST/Counselor** ☐**PT/Counselor**

☐**Other Discipline/Counselor (BS or BA in related Clinical/Educational field) (please name discipline): _____**

☐ **College Student/Assistant Counselor**

(Must be in an approved OT or OTA program) **Major:** ☐**OT** ☐**COTA** **1st yr Student __** **2nd yr Student __** **3rd yr Student __** **4th yr Student__**

(Must be in an approved clinical/educational program) ☐**Other Major (state specific major & student year status) : _____**

The following MUST be attached to your application: Clinicians/Teachers * Students ◊

☐ Copy of resume * ◊

☐ Copy of an updated professional license to submit *

☐ Copy of proof of student status (i.e. transcript or other proof) to submit ◊

☐ Proof of Fingerprint Clearance *◊ (Specify) Dept. of Education __ Dept. of Investigation __ Police Precinct __

(Fingerprint Clearance Option: NYC Police Dept:: 1 Police Plaza, NY, NY 10007, Some local Precincts may also do fingerprint clearance)

Note: OT For Kidz is NOT affiliated with any one of these establishments. This must be done on your one. Fees may apply

☐ Copy of your professional liability insurance to submit *

☐ Copy of a medical within 2 years of week of program. (PPD not needed if medical is completed on NYC DOH medical form) * ◊

☐ A completed background form . This form is on pg 4. **Addresses MUST date back 28 years or to birth* ◊**

☐ Copies of 2 letters of references (professional or personal) * ◊

☐ Check here to acknowledge that you are aware that your participation may include contact with horses, participation in aquatic activities as well as other physical activities. You also acknowledge that you must complete the entirety of this program to receive full credit towards contact hours, NYSOTA approved contact hours and/or volunteer hours. * ◊

Additional Certification (i.e. First Aid, CPR, etc): _____

OTHER INFORMATION:

What do you hope to learn from this experience (state goals): _____

_____

Special Skills/Talents (i.e. yoga, dance, etc): _____

T-shirt Size: Small _____ Medium _____ Large_____ Extra Large_____ Other _____

_____

Signature (By signing, I attest that the completed information is accurate)

Hand in application in-person, Email to Occupationaltherapy4kidz@gmail.com or fax to 718-949-5438

OT For Kidz thank you for your inquiry to participate in our Summer Program, **Kidz in Motion**! Because we get an overwhelming amount of inquiries, unfortunately, all students may not be to register for the counselor assistant position. We will make every attempt to accommodate all. However, we may have positions available as an onsite **Program Support Assistant**. Students in this position will also earn volunteer hours and a certificate of completion. Please include this page when submitting your application.

Program Support Assistant

Responsibilities: Attend all 5 days of the summer program in August 2020. The Program Support Assistant will help prepare for program activities, organize materials, assist in managing communications between parents, counselors, and the directors, give feedback and support in way necessary to help make the program run smoothly.

Target Participants for Program Support Assistant: Preferable College Students in the field of Healthcare and/or Education

Learning Opportunity includes but not limited to

1. Assisting in scoring at least 1 standardized tool
2. Organize and set up for various activities related to program
3. Participate in orientation/in-service geared towards identifying and differentiating between deficits in sensory processing affecting children's functional skills
4. Participate in orientation/in-service geared towards identifying how to integrate sensory integrative concepts into a treatment protocols for children such a w/SPD, ASD, ADHD, LD, DD
5. Observation opportunity and provide assistance with on-site activities and provide support for the program

Please check 1 box

☐ I **prefer** the Counselor Assistant position and my 2nd choice would a Program Support Assistant position

☐ I **prefer** the Program Support Assistant and my 2nd choice would be as a Counselor Assistant position

☐ I'm **NOT** interested in the Program Support Assistant Position

August 10-14, 2020 (Monday-Friday)
Occupational Therapy For Kidz, Specializing in Sensory Integration
219-02 Linden Blvd, Cambria Heights, NY 11411
Time of Program: 7:30 am - 4:30 pm

Orientation: August 8, 2020 (Saturday) Program Support Assistants 12-1 pm
Counselors/Counselor Assistants 1-4 pm

Contact Paula Stewart or Christine Grant for any questions or concerns.

To help you to accurately complete your application, please read below

Common Questions

- Background Check (next page): State Central Register Database
You MUST add all people in which you live.
You MUST include addresses in which you lived dated back 28 years or until birth.
If you lived in another country just include town and country and years in which you lived there.
You may use the 2nd page of the state central register database form if you need more space to place all addresses.

-Fingerprinting Clearance: OT For Kidz are not associated with any fingerprint clearance entity. All must obtain fingerprint clearance or copies of a clearance. A receipt that it has been done does not show proof of clearance. A copy of documents demonstrating Fingerprint clearance from an employer or former employer will be accepted. Some local police departments may also provide fingerprinting, however, they may ask you to bring a fingerprint card. OT for Kidz does not supply these cards. Some previous participants have been successful in fingerprint clearance at the NYC Police Department located at 1 Police Plaza, NY, NY. Please advised that there is a fee and the process may take longer than 2 weeks.

- Reference Letters
Professionals: This may be from a professional associate, an employer or colleague in which you work, etc

Student Volunteer: This may be from a professor, an employed college associate (i.e. an advisor, a guidance counselor, etc), an employer or colleague.

- **Offsite activities** includes getting in pool with your assigned child and being in close proximity to horses. Therefore liability Forms for Horseabilitiy as well as the swimming facility must be signed.

LDSS-3370 (Rev. 04/2011) FRONT

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

STATEWIDE CENTRAL REGISTER DATABASE CHECK

Agency Use Only

SCR USE ONLY
REQUEST I.D.:

ALL INFORMATION MUST BE COMPLETE. PLEASE PRINT OR TYPE

AGENCY CODE:	RESOURCE I.D. (RID)	CHILD CARE FACILITY SYSTEM (CCFS) NUMBER:	CATEGORY USE ALPHA CODE:	PHONE NUMBER (Area Code):
HA4	20915323		Y	(718)949-5439

PRINT BELOW THE ADDRESS ASSOCIATED WITH YOUR RID/CCFS NUMBER:

AGENCY NAME: Occupational Therapy For Kidz Specializing In Sensory Integration, LLP

AGENCY LIAISON: Paula Stewart

STREET ADDRESS 219-02 Linden Blvd

CITY: Cambria Heights **STATE:** NY **ZIP CODE:** 11411

The particular classifications of persons who must or may be screened are set forth on the reverse side of this document. The alpha codes to complete the "Category" box above are also on the reverse side of this form

FOR ALL CATEGORIES: Complete the following for yourself, your spouse, your children and any other person(s) in your home at the present time. MAKE SURE YOU COMPLETE ALL MAIDEN NAME/ALIAS SECTIONS THAT APPLY. IF NONE, STATE "NONE" *List RELATIONSHIP in the fields below*

(see reverse side for instructions) Attach additional page if necessary.

The purpose of collecting the demographic data on *other persons in your household* who are not screened pursuant to Section 424-a of the Social Services Law is to enable the N.Y.S. Office of Children and Family Services to identify with the greatest degree of certainty whether the person(s) being screened is the subject of an indicated child abuse or maltreatment report. The utilization of this information in a discriminatory manner is contrary to the Human Rights Law.

APPLICANT/HOUSEHOLD MEMBER AREA ***PLEASE TYPE OR PRINT CLEARLY**

RELATIONSHIP TO APPLICANT	LAST NAME	FIRST NAME	SEX M/F	DATE OF BIRTH
APPLICANT				
MAIDEN/ALIAS				

Please provide your current address and any other addresses at which you have resided for the last 28 years, including street, city and state. For Adoption, Foster Care, Family and Group Family Day Care, also include the same address history for household members 18 of age and older.

	APT #	CITY	STATE	ZIP	FROM	TO
CURRENT STREET ADDRESS						
PREVIOUS STREET ADDRESS						
PREVIOUS STREET ADDRESS						
PREVIOUS STREET ADDRESS						
PREVIOUS STREET ADDRESS						

I affirm that all the information provided on this form is true to the best of my knowledge. I understand that if I knowingly give false statements, such action could be grounds for denial or dismissal from employment or denial or revocation of a license, certificate, permit, registration or approval.

APPLICANT'S SIGNATURE	DATE

APPLICANT'S SIGNATURE	DATE

EIGHTEEN YEARS OLD OR OVER:

I understand that as a person eighteen years of age or over in a home of an applicant to become an Adoptive or a Foster Parent or a Family or Group Family Day Care provider, the information I have provided will be used to inquire of the Statewide Central Register to determine if I am the subject of an indicated report of child abuse or maltreatment.

SIGNATURE	DATE

SIGNATURE	DATE

goldfish swim school®
Where the experience is golden.

Goldfish Waiver

Parent or Guardian Name(s)_____ and _____

1st Child: First_____ Last_____ Date of Birth_____ Age_____ Sex_____

2nd Child: First_____ Last_____ Date of Birth_____ Age_____ Sex_____

3rd Child: First_____ Last_____ Date of Birth_____ Age_____ Sex_____

4th Child: First_____ Last_____ Date of Birth_____ Age_____ Sex_____

Home Address: Street_____ City_____ State_____ Zip_____

Phone Number: Home_____ Cell 1_____ Cell 2_____

Preferred Email Address(es)_____

How did you hear about us?_____

Emergency Contact 1_____ Phone Number_____ Relationship to Student_____

Emergency Contact 2_____ Phone Number_____ Relationship to Student_____

Medical History: Please list any medical conditions (allergies, special needs, etc.) that we should be aware of while working with your child _____

Informed Consent and Waiver/Release of Liability Parent

The undersigned, both individually, and as the parent, legal, or supervising guardian of the participating child(ren) listed on this Agreement and on their behalf (Parent and Child(ren) are collectively the "Participant"), agree and understand that swimming is a hazardous activity and involves some element of personal risk. You understand that these risks are inherent in and incidental to the sport of swimming, including, but not limited to, paralyzing injury and death. The Participant hereby assumes these risks and dangers.

In consideration of the Participant being permitted to participate in the swim lessons, events, parties, and programs, and to otherwise make use of the facilities (collectively the "Programs") of BHB Investment Holdings Garden City, LLC ("Goldfish," which term includes the "Released Parties," defined below), the Participant recognizes and assumes the risks, hazards and dangers of injuries from their participation in the Program. The Participant, on his or her own behalf and on behalf of any persons claiming by, through or under him or her, hereby waives, releases and forever discharges any and all claims or causes of actions which the Participant may have now or hereafter against Goldfish, whether known or unknown, arising out of any injuries or damage that the Participant may sustain in connection with his or her participation in the Program and will indemnify and hold Goldfish harmless against any and all such claims or causes of action. The Participant's covenant to indemnify and hold Goldfish harmless includes Goldfish's attorneys' fees and costs incurred in connection to the claim or cause of action. The Participant's waiver, release, discharge and agreement to indemnify and hold Goldfish harmless extends to Goldfish and its respective officers, directors, members, managers, agents, employees and affiliated companies, and its franchisor and its officers, directors, members, managers, agents, employees and affiliated companies (collectively, the "Released Parties"). The Participant hereby further agrees not to sue Goldfish for the claims waived and released in this Agreement. The Participant further agrees to indemnify and hold harmless Goldfish from claim or liability from any injury (including death) to any other person(s) caused by or related to actions of the Participant. The Participant expressly understands that he or she is agreeing to waive, release, not sue, indemnify and hold harmless Goldfish for any claims, liability, damages or losses arising from injuries to or caused by the Participant while engaged in the Goldfish Programs. Participant further agrees and understands that he or she will be responsible for Goldfish's attorney's fees and cost incurred in the event the Participant breaches this Agreement.

Goldfish assumes no responsibility for any personal property used, placed in or about the facility.

If a provision of this Agreement is declared invalid or unenforceable by a court of competent jurisdiction then it shall be reduced in scope so as to provide Goldfish with the maximum protection allowed by law and it shall not affect the validity or enforceability of any other provision. Any legal action arising from or related to the Participant's participation in the Program or this Agreement shall be commenced in the county in which the BHB Investment Holdings Garden City, LLC is located.

The Participant authorizes Goldfish to treat or have Participant treated in any medical emergency during their participation in the Goldfish Programs. Further, the Participant agrees to pay all costs associated with medical care and transportation for the Participant.

Photos and/or Video

I understand that photos and/or video is taken at GSS and that any photo and/or video taken of my child(ren) may be used for Goldfish publicity purposes.

I have read and understand, and I agree with the informed Consent and Waiver/Release of Liability outlined above and the Registration and Payment Policies form outlined on the reverse side of this page as it relates to me and my child(ren).

_____

Parent or Guardian Signature | Printed Name | Date

HORSEABILITY
CENTER FOR EQUINE FACILITATED PROGRAMS

CAMP AND RIDING INSTRUCTION AGREEMENT AND LIABILITY RELEASE

CAMP HORSEABILITY, INC, 223 Store Hill Road /Steele Hill Road, Westbury NY, hereinafter known as "HORSEABILITY" at the SUNY College at Old Westbury as well as all satellite locations including "Camp Loyaltown" on Glen Ave in Hunter, NY

CAMP HORSEABILITY, INC, 238 Round Swamp Road, Melville, NY, hereinafter known as "CAMP HORSEABILITY" at the Thomas School of Horsemanship

PLEASE READ CAREFULLY BEFORE SIGNING
SERIOUS INJURY MAY RESULT FROM YOUR or YOUR CHILD'S PARTICIPATION IN THIS ACTIVITY. HORSEABILITY CANNOT GUARANTEE YOUR SAFETY.

A. REGISTRATION OF RIDERS AND AGREEMENT PURPOSE: In consideration of the payment of a fee and the signing of this agreement, We, the parents of the minors listed on the registration form do hereby voluntarily request and agree to our child(ren)'s participation in riding, at HORSEABILITY, and that this STUDENT will either ride his/her own horse, or school horses provided by HORSEABILITY for instructional purpose, today and on all future dates.

B. AGREEMENT SCOPE AND TERRITORY AND DEFINITIONS: This agreement shall be legally binding upon the registered STUDENT, and/or the parents or legal guardians thereof if a minor, my heirs, estate, assigns, including all minor children, and personal representatives; and it shall be interpreted according to the laws of New York State and Suffolk County. Any disputes with the rider shall be litigated in, and venue shall be in, Suffolk County. If any clause, phrase, or word is in conflict with state law, then that single part is null and void. The term "HORSE" herein shall refer to all equine species. The term "HORSEBACK RIDING" herein shall refer to riding or otherwise handling of horse, ponies, mules, or donkeys, whether from the ground or mounted. The terms "CAMPER" and/or "RIDER" shall herein refer to a person who rides a horse mounted or otherwise handles or comes near a horse from the ground. The term "I/WE" shall herein refer to the riding school student or parents of the registered student on the opposite side.

C. ACTIVITY RISK CLASSIFICATION: I/WE UNDERSTAND THAT: Horseback riding is classified as RUGGED ADVENTURE RECREATIONAL SPORT ACTIVITY and that there are numerous obvious and non-obvious inherent risks always present in such activity despite all safety precautions.

D. NATURE OF HORSEABILITY'S HORSES: I/WE UNDERSTAND THAT: HORSEABILITY chooses its horses for their calm dispositions and sound basic training as is required for use for STUDENT RIDERS and HORSEABILITY follows a rigid safety program. Yet, no riding horse is a completely safe horse. Horses are 5 to 15 times larger, 20 to 40 times more powerful, and 3 to 4 times faster than a human. If a rider falls from horse to ground it will generally be a distance of from 3 1/2 to 5 1/2 feet, and the impact may result in injury to the rider. Horseback riding is the only sport where one much smaller, weaker predator animal (human) tries to impose its will on, and become one unit of movement with, another larger, stronger prey animal with a mind of its own (horse) and each has a limited understanding of the other. If a horse is frightened or provoked it may divert from its training and act according to its natural survival instincts which may include, but are not limited to: Stopping short; Changing directions or speed at will; Shifting its weight; Bucking, Rearing, Kicking, Biting, or Running from danger.

E. CONDITIONS OF NATURE AND INSPECTION OF PREMISES: I/WE UNDERSTAND THAT: HORSEABILITY is NOT responsible for total or partial acts, occurrences, or elements of nature that can scare a horse, cause it to fall, or react in some other unsafe way. SOME EXAMPLES ARE: thunder, lightening, rain, wind, wild and domestic animals, insects, reptiles, which may walk, run, or fly near, or bite or sting a horse or person; and irregular footing on out-of-doors groomed or wild land which is subject to constant change in condition according to weather, temperature, and natural and man-made changes in landscape. WE have inspected HORSEABILITY'S facilities and are satisfied that all premise conditions are reasonably safe for rider's intended purpose, usage, and presence upon HORSEABILITY'S PREMISES.

F. SADDLE GIRTHS/NATURAL LOOSENING I / WE UNDERSTAND THAT: Saddle girths (saddle fasteners around horse's belly) may loosen during a ride. If a rider notices this he/she must alert the riding instructor as quickly as possible so action can be taken to avoid slippage of saddle and a potential fall from the animal.

G. ACCIDENT/MEDICAL INSURANCE WE AGREE THAT: Should emergency medical treatment be required, WE and/or my own accident/medical insurance company shall pay for all such incurred expenses. PLEASE PROVIDE ON REVERSE SIDE.

H. PROPER ATTIRE FOR SAFTEY: ASTM APPROVED PROTECTIVE HEADGEAR IS REQUIRED: I/WE AGREE: to purchase protective or borrow from HorseAbility, headgear which meets or exceeds the quality standards of the SEI CERTIFIED ASTM STANDARD F 1163 Equestrian Helmet. It will be worn while riding and being near horses and WE do understand that the wearing of such headgear at these times may reduce the severity of some of the wearer's head injuries and possibly prevent the wearer's death from happening as the result of a fall and other occurrences. All riders must wear proper footwear, boot with smooth sole and ¼" heal. If sneakers must be worn due to inability to wear boots, when riding with stirrups, tack will be adjusted to accommodate exception to attire.

I. LIABILITY RELEASE: I/WE AGREE THAT: In consideration of THIS PROGRAM/SCHOOL allowing myself or our child's participation in this these riding activities, under the terms set forth herein, I or WE, the parents, for ourselves and on behalf of our child(ren) and/or legal ward, heirs, administrators, personal representatives or assigns, do agree to hold harmless, release, and discharge HORSEABILITY, its owners, agents, employees, officers, directors, representatives, assigns, members, owners of premises and trails, affiliated organizations, and Insurers, and others acting on its behalf(hereinafter, collectively referred to as "Associates"), of and from all claims, demands, causes of action and legal liability, whether the same be known or unknown, anticipated or unanticipated, due to HORSEABILITY'S and/or ITS ASSOCIATES ordinary negligence; and I or WE, the parents, do further agree that except in the event of HORSEABILITY'S gross negligence and willful and wanton misconduct, WE shall not bring any claims, demands, legal actions and causes of action, against HORSEABILITY and ITS ASSOCIATES as stated above in this clause, for any economic and non-economic losses due to bodily injury, death, property damage, sustained by me and/or my minor child or legal ward in relation to the premises and operations of HORSEABILITY, to include while riding, handling, or otherwise being near horses owned by or in the care, custody and control of HORSEABILITY, or participating in any of the school activities, whether on or off the premises of HORSEABILITY.

LIABILITY CONSENT AND EMERGENCY MEDICAL RELEASE

Name: _____ DOB: _____ ☐ Participant ☐ Staff ☐ Volunteer

Phone: _____ Email : _____

Address: _____

Physician's Name: _____ Preferred Medical Facility: _____

Health Insurance Carrier: _____ Policy #: _____

Allergies: _____

Current medications: _____

In the event of an emergency, contact:

Name: _____ Relation: _____ Phone: _____

Name: _____ Relation: _____ Phone: _____

In the event emergency medical aid/treatment is required due to illness or injury during the process of receiving services, or while being on the property of the agency, I authorize HORSEABILITY 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 emergency treatment.

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

☐ **I AGREE and Consent to Plan**

☐ **I DO NOT AGREE; Please Follow my 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 the agency. Parent or legal guardian will remain on site at all times during equine assisted activities*

NON CONSENT PLAN - _____

SIGNER STATEMENT OF AWARENESS

I/WE, THE UNDERSIGNED, HAVE READ AND DO UNDERSTAND THE FOREGOING AGREEMENT, WARNINGS, RELEASE AND ASSUMPTION OF RISK. WE FURTHER ATTEST THAT ALL FACTS RELATING THE CAMPER'S PHYSICAL CONDITION, EXPERIENCE, & AGE ARE TRUE AND ACCURATE.

BY SIGINING BELOW YOU ARE AGREEING TO THE TERMS ON THE REVESE SIDE OF THIS FORM

X SIGNATURE OF PARENT (OR RIDER IF OVER 21) _____ **DATE** _____

HorseAbility | PO Box 410-1 Old Westbury NY 11568 | phone 516.333.6151 | fax 516.333.5295 | email info@horseability.org | web www.horseability.org