ANIMALS AS NATURAL THERAPY

Transforming our community, one person at a time

Participant Registration & Release

Name:	Date of Birth:	Age:	Weight:	Height: *(for horsemanship)*
Street Address:	City:			
State:	Zip Code:			
Primary Caretaker:	Phone:			
Relationship to participant:	Email address:			
Address/Phone if different from above				
School/Institution attending:				
Were you referred by a school counselor?	Yes ☐ No ☐	Name:		
How did you hear about ANT?				

Liability Release:

__________________________(Participant's name) would like to participate in the Animals as Natural Therapy programs. I acknowledge the risks and potential for risks of horse and farm activities. However, I feel that the possible benefits to myself/ my son/ my daughter/ my ward are greater than the risk 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 Windy Acres and Animals as Natural Therapy, Inc., its Board of Directors, Instructors, Therapists, Volunteers and/or Employees for any and all injuries and/or losses I/ my son/ my daughter/ my ward may sustain while participating in Animals as Natural Therapy programming. I understand that these programs may include therapeutic counseling.

Date: ____________ Signature:________________________________

Participant, Parent or Guardian

Photo Release (OPTIONAL):

I hereby consent to and authorize the use and reproduction by Animals as Natural Therapy of any and all photographs and any other audiovisual materials taken of me/ my son/ my daughter/ my ward for promotional printed materials, educational activities or for any other use for the benefit of the program.

Date: ____________ Signature:________________________________

Participant, Parent or Guardian

Participant's Authorization for Emergency Medical Treatment

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 Animals as Natural Therapy to secure and retain medical treatment and transportation if needed.

Full Name:	DOB:	Age:	Gender:
Primary Caretaker:	Relationship:		Phone:
Emergency Contact:	Phone:		
Emergency Contact:	Phone:		
Name of physician:	Phone:		
Health Insurance Co:	Policy #:		
Preferred Medical Facility:			

Consent Plan

This authorization includes x-ray, surgery, hospitalization, and medication and any treatment procedure deemed "lifesaving" by the physician. This provision will only be invoked if the person below is unable to be reached.

Print Name:	Relationship to Participant:
Consent Signature:	Date:

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. **In the event of emergency treatment/aid is required, I wish the following procedures to take place:**

Print Name:	Relationship to Participant:
Non-Consent Signature:	Date:

Participant's Medical History

Full Name:	DOB:	Gender:
Form completed by:	Relationship:	
What goals do you have for your child's time at ANT? *required to participate*		
Any known allergies:	Date of last tetanus:	
What is your child's reaction to bee stings?		
Any medications the youth will be taking during visits or to be aware of in an emergency?		
Any health reasons to limit child's activities/ at farm?		
Any diet restrictions?		

GENERAL QUESTIONS: Complete information is needed to insure instructor awareness and sensitivity to your child's behavior and needs, and will not be used to screen out participants.

	Yes	*No*
1. Any recent injury, illness, or infectious disease?	☐	☐
2. Chronic recurring illness/condition?	☐	☐
3. Frequent headaches?	☐	☐
4. Ever had head injury?	☐	☐
5. Wear glasses, contacts, or protective eyewear?	☐	☐
6. Use mobility device(s) or hearing aids?	☐	☐
7. Ever passed out during or after exercise?	☐	☐
8. Ever had seizures?	☐	☐
9. Chest pain during or after exercise?	☐	☐
10. High blood pressure?	☐	☐
11. Back problems?	☐	☐
12. Joint problems (e.g., knees, ankles)?	☐	☐
13. Orthodontic appliance or headgear being used?	☐	☐
14. Any skin problems (e.g., allergies, rash, hives)?	☐	☐
15. Diabetic?	☐	☐
16. Asthmatic?	☐	☐
17. ADD/ADHD diagnosed?	☐	☐
18. Short or long-term memory impairment?	☐	☐

19. Tendencies toward emotional/violent outburst or inflicting harm to self, others or animals?	☐	☐
20. Tendencies toward emotional/physical isolation?	☐	☐

Please explain any "yes" answers, noting the number of the question.

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PARTICIPANT DEMOGRAPHICS:

Participant Resides in:

- o Town or Rural Non-farm (pop. 10,000 or less)
- o Town or City (pop. 10,000-50,000)
- o Suburb (pop. 50,000 or more)
- o City (pop. 50,000 or more)
- o Reservation
- o Farm
- o Other

Participant lives with:

- o 1 Biological Parent
- o Both Biological Parents
- o Blended Family
- o Alternates between 2 parents
- o Other Relative
- o Foster Family
- o Adoptive Family
- o Other: ______________________

Racial/Ethnic Group

- o Caucasian
- o African American
- o Native American
- o Hispanic/Latino
- o Asian/Pacific Islander
- o Other: _________________

School Grade:

o K	o 7th
o 1st	o 8th
o 2nd	o 9th
o 3rd	o 10th
o 4th	o 11th
o 5th	o 12th
o 6th	o Not attending

Check if 'Yes':

- o Has the participant ever resided with anyone other than his/her birth family?
- o Is the participant struggling academically?
- o Is the participant struggling behaviorally or emotionally in school?
- o Is the participant struggling behaviorally or emotionally in social situations?
- o Is the participant struggling behaviorally or emotionally at home?
- o Has the participant or a close family member ever been incarcerated?
- o Has the participant witnessed or experienced domestic violence?
- o Has the participant or a close family member abused/had any problems with alcohol or drugs?
- o Is a close family member active in the military or a veteran?
- o Does the participant identify as LGBTQ?

To the best of my knowledge, the above is up to date and accurate.

_______________________________________ ______________

Signature Date

Participant Financial Agreement

Charges for ANT's after-school program are $75 per 90-minute session. This is $675 per 9-week quarter, with **payment in full due by the seventh week of the quarter.** Please refer to your Parent Letter for specific program dates. Monthly statements will be sent to reflect the total amount due for the quarter. This statement will also show any financial assistance granted.

Limited scholarships are available based on a sliding fee scale. To apply, please contact our program coordinator. Financial Assistance Forms must be submitted at least three weeks before the beginning of the quarter in order to have time to process and approve requests. Proof of income is required.

Absence Policy:

- Volunteer mentors commit their time to work with your child to ensure a safe and successful session – we ask that you honor this commitment by attending every session.
- Please notify us **at least 2 hours in advance** if your child will be absent. Your child is considered "unexcused" if notice is given less than 2 hours prior to their session time.
- We understand that emergencies do arise; however, **an instructor fee will be charged for last minute cancellations & unexcused absences, equal to:**
    - *Half the normal session fee for full-pay participants*
    - *Full session fee for scholarship participants*
- If a participant misses two (2) sessions without notice, future sessions will be cancelled for the quarter and no further financial assistance will be given.

Financial Assistance:

Organization providing funding: ______________________ Amount granted: $______________

Contact person: ______________ Phone: __________ Email: ______________

Other funding source: ______________________ Amount granted: $______________

Contact person: ______________ Phone: __________ Email: ______________

Family agrees to pay: $______________________________

ANT Scholarship/Financial Assistance awarded: $______________________________

I have read this policy and understand that I am responsible for full payment of this account.

Name of participant: ______________________________

Name of responsible party: ______________________________

Signature of Responsible Party: ______________________________ Date: ______________

Must be Parent or Guardian if participant is under 18 years old

Thank you for allowing Animals as Natural Therapy to assist your child in his/her experiential education.

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