



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 <input type="checkbox"/> No <input type="checkbox"/> Name:				
How did you hear about ANT?				

Day Camp Week Preferred: _____ Please see Website for Dates
T-Shirt Size: ____ Youth ____ Adult

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 and their contracted services/funders 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?	<input type="checkbox"/>	<input type="checkbox"/>
2. Chronic recurring illness/condition?	<input type="checkbox"/>	<input type="checkbox"/>
3. Frequent headaches?	<input type="checkbox"/>	<input type="checkbox"/>
4. Ever had head injury?	<input type="checkbox"/>	<input type="checkbox"/>
5. Wear glasses, contacts, or protective eyewear?	<input type="checkbox"/>	<input type="checkbox"/>
6. Use mobility device(s) or hearing aids?	<input type="checkbox"/>	<input type="checkbox"/>
7. Ever passed out during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>
8. Ever had seizures?	<input type="checkbox"/>	<input type="checkbox"/>
9. Chest pain during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>
10. High blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>
11. Back problems?	<input type="checkbox"/>	<input type="checkbox"/>
12. Joint problems (e.g., knees, ankles)?	<input type="checkbox"/>	<input type="checkbox"/>
13. Orthodontic appliance or headgear being used?	<input type="checkbox"/>	<input type="checkbox"/>
14. Any skin problems (e.g., allergies, rash, hives)?	<input type="checkbox"/>	<input type="checkbox"/>
15. Diabetic?	<input type="checkbox"/>	<input type="checkbox"/>
16. Asthmatic?	<input type="checkbox"/>	<input type="checkbox"/>
17. ADD/ADHD diagnosed?	<input type="checkbox"/>	<input type="checkbox"/>
18. Short or long-term memory impairment?	<input type="checkbox"/>	<input type="checkbox"/>

19. Tendencies toward emotional/violent outburst or inflicting harm to self, others or animals?	<input type="checkbox"/>	<input type="checkbox"/>
20. Tendencies toward emotional/physical isolation?	<input type="checkbox"/>	<input type="checkbox"/>

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

PARTICIPANT DEMOGRAPHICS:

Participant Resides in:

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

Racial/Ethnic Group

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

Participant lives with:

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

School Grade:

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

Check if 'Yes':

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

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

Signature

Date



Rain or Shine Policy

Animals as Natural Therapy programs operate rain or shine. In the case of inclement weather or natural disaster ANT staff will contact you at least 2 hours prior to your committed time to cancel.

I have read this policy and understand that I am committed to showing up for camp unless ANT has cancelled.

Name of responsible party: _____

Signature of Responsible Party: _____ Date: _____

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



Participant Financial Agreement

A \$25 non-refundable application fee is due with your completed registration paperwork. This fee will be applied towards the total price of the camp.

Prices for ANT's Day Camps are as follows:

- \$550 for Full 5 Day Camp
- \$440 for 4 Day Camp
- \$325 for Half-Day Camp

Payment for all Day Camps must be made in full by June 1 to insure your registration.

Cancellations and Refunds

We understand that life happens, regardless of best laid plans. We also know summer camps are put into action based on enrollment expectations. Refund amounts are based on how far in advance your cancellation is made. **Specific refund requests may be made due to family or medical emergency.**

- 50% refund (excluding \$25 application fee) before June 15, 2020
- No refunds after June 15, 2020

Your non-refunded camp payment will be applied towards a scholarship for a youth in need.

Limited scholarships are available based on a sliding fee scale. To apply, please contact our program coordinator at program@animalsasnaturaltherapy.org. Financial Assistance Forms must be submitted by May 1, 2020. Proof of income is required.

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 choosing Animals as Natural Therapy for a great week of day camp!
721 Van Wyck Road, Bellingham WA, 98226 / www.animalsasnaturaltherapy.org / 360-671-3509