ANIMALS AS NATURAL THERAPY

Participant Registration & Release

Name:		Date of Birth:	Age:	Pronouns (optional):
Weight:	Height:	(For Riding Horses)		
Street Address:		City:		
State:		Zip Code:		
Primary Caretaker:		Phone:		
Relationship to participant:		Email:		
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 (REQUIRED):

_____(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 my child 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 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 child/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/Media 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 child for promotional printed materials, educational activities or for any other use for the benefit of the program.

Date: _____ Signature:_____

Participant, Parent or Guardian

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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:
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: _____

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: _____

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Exceptions to Confidentiality

The privacy of your personal information is of utmost importance. ANT is compliant with current Federal and State of Washington laws. Federal and State laws limit confidentiality. ANT may use or disclose your personal health information when required or permitted to do so by law, or in the following situations:

a) Duty to warn: Participant's personal health information may be disclosed if we determine a need to alert an intended victim of a serious threat to their health or safety. For example, this may occur if participants reveal intentions to kill or harm another person. ANT is obligated to take necessary action to avert a serious threat to the health and safety of others.

b) Danger to participant: Participant's personal health information may be disclosed if ANT determines that participants may kill or seriously harm themself. For example, this may occur if participants reveal that they are planning to attempt suicide. ANT is obligated to take necessary action to avert a serious threat to their health or safety.

c) Child or elder abuse or neglect: Participant's personal health information may be disclosed if they report or ANT reasonably suspects any child or elder abuse or neglect. For example, if participants reveal that they have physically harmed a child then ANT will need to notify Child Protective Services (CPS).

d) Court order: Participant's personal health information may be disclosed if ANT is presented with a court order to do so. For example, this may occur if participants have legal involvement and a judge or law enforcement agency has called ANT to testify or release records.

e) Crime against ANT or office premises: participant's personal health information may be disclosed if they commit or threaten to commit a crime against ANT or within office premises. This includes damage to property.

f) Other disclosures: participant's personal health information may be disclosed for research when approved by an institutional review board, to military or national security agencies, coroner, medical examiners, and correctional institutions or otherwise as authorized by law. Participant's personal health information may be disclosed to necessary parties involved if you file a legal or administrative claim against me or my business. Your identifying information may be disclosed to debt collection agency personnel if you fail to pay for ANT's professional services by our agreed upon time period.

Date: _____ Signature:_____

Participant (if over 18), Parent or Guardian

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Participant Information & Medical History

What goals do you have for your child's time at ANT? *required*
Any known allergies: Date of last tetanus:
What is your child's reaction to bee stings?
Any medications the youth will be taking during program(s) or to be aware of in an emergency?
Any health reasons to limit child's activities?
Anything else we should know?

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. Check all that apply.

- ◯ Any recent injury, illness, or infectious disease?
- ◯ Chronic recurring illness/condition?
- ◯ Frequent headaches?
- ◯ Ever had head injury?
- ◯ Wear glasses, contacts, or protective eyewear?
- ◯ Use mobility device(s) or hearing aids?
- ◯ Ever passed out during or after exercise?
- ◯ History of seizures?
- ◯ Chest pain during or after exercise?
- ◯ High blood pressure?
- ◯ Back or Joint problems?
- ◯ Orthodontic appliance or headgear being used?
- ◯ Any skin problems (e.g., allergies, rash, hives)?
- ◯ Diabetic?
- ◯ Asthmatic?
- ◯ ADD/ADHD diagnosed?
- ◯ Short or long-term memory impairment?
- ◯ Tendencies toward emotional/violent outbursts?
- ◯ History of inflicting harm to self/others/animals?
- ◯ Tendencies toward emotional/physical isolation?

Please explain any 'yes' answers: _____

_____

_____

_____

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 close family member had problems with drugs or alcohol?
- 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

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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 program start 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

ANIMALS AS NATURAL THERAPY

Covid-19 Acknowledgement of Risk and Acceptance of Services

I, _____ (name), am aware of the risks of myself/my child/my ward contracting Covid-19 while receiving face to face services from Animals as Natural Therapy (ANT) at this time of the pandemic.

I am aware that face to face services increase my risk of contracting and passing on Covid-19 or Coronavirus and agree to hold harmless ANT, its employees, and all other individuals I/my child/my ward may come in contact with during this interaction and receiving of services.

I/my child/my ward agree to and will follow all guidelines for personal hygiene, personal safety and public safety as recommended by ANT. This may include, but is not limited to, waiting in vehicle until asked to enter the building/barnyard; washing hands prior to each session; use of hand sanitizer upon request; wiping down surfaces with disinfecting wipes and/or wearing a protective medical mask and/or gloves.

I agree to cancel my session/program should I/my child/my ward have within the previous 24 hours to 2 weeks personally exhibited or have been in contact with someone who has presented with illness including; cough, sneezing, fever, chest congestion or additional signs of potential spread of any virus or bacteria/disease. I will notify ANT staff if I or my child/my ward comes down with any of these symptoms in the 2 weeks following our session/program. In addition, I will follow the recommendations of ANT staff once I have notified them of these risks in regards to my future services during this pandemic.

Animals as Natural Therapy will engage in regular cleaning and sanitizing of horse tack, grooming supplies and office, doors, and frequently touched areas in-between participants/volunteers and on a daily basis as recommended by the CDC and our contracted Veterinarian for the safety of participants, employees, volunteers and animals.

I am signing under my own free will and choice and agree to follow these and hold harmless all individuals associated with or through my services acquired from Animals as Natural Therapy.

Participant Name:_____ Date: _____

Participant Signature: _____

Parent/Guardian Name (if under 18):_____ Date: _____

Parent/Guardian Signature: _____

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2022 Participant Financial Agreement

Charges for ANT's after-school program are $140 per 90-minute group session. This is $1260 per 9-week quarter, with payment in full due by the seventh week of the quarter. Private sessions (with a therapist present) are $175 for 60-minutes; payment due weekly. Monthly statements will be sent to reflect the total amount due for the quarter. This statement will also show any financial assistance granted.

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 agreed-upon 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: $_____ *Required for participation

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 support your child.

Po Box 31595, Bellingham WA, 98228 / www.animalsasnaturaltherapy.org / 360-671-3509