Saving Grace Farm, Inc.
Providing Saving Grace Therapeutic Programs
725 Jackson Road
Salisbury, NC 28146
Ph (704) 209-6577 Fax (704) 603-3022
www.savinggracefarm.com

Dear Veteran/Caregiver,

Thank you for considering joining our Mounted Warrior Program! We are excited to have you on board! Please see the attached packet and complete any information that applies to you.
If you have any questions please give us a call! We will be happy to assist you in completing these forms.

Each visit is about an hour in length and occurs once a week at your scheduled time. Funding for the Veterans program will cover up to 10 weeks of services. Please try to plan to attend each appointment, as once you are on the schedule, that time slot is set aside just for you or your family. Our staff and volunteers prepare for your visit and often drive from 20-30 minutes away to be there just for you! If you are running late, or cannot make it to your visit please let us know as soon as possible.

There is a form at the back of the packet that needs a Physician to complete it. You do not have to return it to us before your first visit. It can be faxed or mailed to our office at the number or address above, or you can bring it to your second or third visit.

Once your part of the forms are complete, please give us a call to set up your visits. If you need help with your paperwork you may call and bring it to your first visit.

We look forward to having you!

Sincerely,

Saving Grace Farm Staff

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PREMIER ACCREDITED CENTER
PATH INTERNATIONAL
Professional Association of Therapeutic Horsemanship International

Veteran/Active Service Member Application and Health History

All Answers are Required unless they Do Not Apply to You

Participant: _____
DOB: _____ Age: _____ Height: _____ Weight: _____ Gender: M F
Address: _____
Phone: _____ Alternative #: _____
Email_____
Are you an Alumni/Member of Wounded Warrior Project? Yes No
Branch of Military:_____ Military Start date (estimate):___/___/___ End date: ___/___/___
Service Status (retired, honorable discharge, etc):_____ Rank:_____
Service Connected Injury/Trauma Date (estimate):___/___/___
Type of Injury: ___Amputee ___PTSD ___SFW/GSW ___Blind
___SCI ___Vision Impaired ___Burn
___TBI ___Hearing Impaired ___Other (describe below)
Other Description:_____

HEALTH HISTORY

In the event of an emergency, contact:
Name: _____ Relation: _____ Phone: _____
Name: _____ Relation: _____ Phone: _____

Please indicate current or past special needs in the following areas:

	Y	N	**Comments** (please comment for every "yes" answer)
Vision			
Hearing			
Sensation			
Communication			
Heart			
Breathing			
Digestion			
Elimination			
Circulation			
Emotional/Mental Health			
Behavioral			
Pain			
Bone/Joint			
Muscular			
Thinking/Cognition			
Allergies			

Describe your abilities/difficulties in physical function: (include assistance required or equipment needed)**:**
(i.e. Mobility skills such as transfers, walking, wheelchair use, driving/bus riding)

_____

_____

_____

Are you on medications that cause drowsiness, disorientation, or instability? Yes or No
If yes, please list:

_____

PHOTO/VIDEO RELEASE (check one)

I __ DO
__ DO NOT

consent to and authorize the use and reproduction by Saving Grace Therapeutic Programs of any and all photographs and any other audio/visual materials taken of me for promotional material, educational activities, exhibitions or for any other use for the benefit of the program. I understand that upon consent the material will only be used in a respectful manner and only by the center named above.

Signature: _____ Date: _____
Client, Parent or Legal Guardian

Confidentiality Policy: I understand that for the purpose of assisting volunteers in providing safe and responsible services to participants, Saving Grace will release information pertaining to the person's ability only as deemed necessary by center staff. Information will not leave Saving Grace Farm except for what is required to enroll you in Wounded Warrior Project.

Signature: _____ Date: _____
Client, Parent or Legal Guardian

Saving Grace Farm works to find sponsors/grants/donors so the Mounted Warriors program is FREE to you. One of the ways we receive funding to provide these services is through organizations like Wounded Warrior Project or the Adaptive Sports Grants.

For Veterans with service connected illness/injury, after 9/11/01:

Our accrediting organization, PATH International, has partnered with Wounded Warrior Project, to provide these services to you, as a Veteran, free of charge. If you are NOT already an alumni/member of WWP, we must provide documentation to WWP for verification. We ask that you please attach a copy of any ONE of the following: your DD 214 Service 2 or Member 4, VA Rating Decision Letter, Line of Duty (LOD) Documentation, MEB/PEB Narrative Summary, ERB or ORB document, or WTU orders. Only one of these documents is needed.

If you are unable to attach the information at this time, please have it sent to us ASAP.

PLEASE NOTE: This documentation is needed only to verify your eligibility for WWP programs. Feel free to black/white out your social security number or other information of a sensitive nature on any document you submit.

In order to cover the cost of your services, you will need an Alumni account through Wounded Warrior Project. Through this account you will have access to other WWP sponsored events and programs that you may enjoy or that can help you on your journey through life. You may do this yourself, however if you would like, we can set up a username and temporary password for your account. Please list your choices for these below.

Username: firstnamelastname (username is always your first and last name)
Password: _____ (please choose a password you will remember)
Security Question: What is your mother's maiden name?
_____ (this will be the answer you must enter to answer this question)

Liability Release Form

CLIENT NAME: _____ AGE: _____

Address: _____ City: _____ State: _____ Zip: _____

PLEASE READ CAREFULLY BEFORE SIGNING

A. I UNDERSTAND THAT Saving Grace Farm AKA Saving Grace Therapeutic Programs (SGTP) are in an outdoor location in nature with various hazards including, but not limited to: ponds, ditches, steep inclines, animals, insects, poison oak/ivy, snakes, etc. and that there are inherent risks always present in such a location. Knowing these risks, I will be responsible for myself, and my own safety.

B. I UNDERSTAND THAT horseback riding and horse activities are classified as a rugged recreational sport activity, and that there are numerous obvious and non-obvious inherent risks always present in such activity despite all safety precautions. I further understand that no horse is completely predictable, and that even well trained horses can become frightened and spook, may divert from its training and act according to its natural survival instincts which may include, but are not limited to: sudden stopping, stopping short, changing directions or speed at will, shifting its weight, bucking, rearing, kicking, biting, or running from danger.

C. I UNDERSTAND THAT SGTP are 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, water, wild or domestic animals, insects, and reptiles.

D. I UNDERSTAND THAT participants must not carry loose items around horses which may fall, blow away, flap in the wind, bounce, or make sharp noises, possibly scaring a horse. Some examples are cameras, hats not securely fastened under chin, toys. Riders should not make sharp, loud noises, such as screaming or yelling, which may scare a horse.

E. I AGREE THAT should emergency medical treatment be required, I and/or my own accidental/medical insurance company **shall pay for all** such incurred expenses.

F. I UNDERSTAND THAT ALL riders must wear protective headgear regardless of age/ability.

G. **I AGREE THAT** pursuant to the General Statutes of North Carolina, Chapter 99E, Special Liability Provisions, Article 1, Equine Liability Activity Liability, and under the terms set forth herein, I, the participant (or parent if under 18), and on behalf of my child and/or legal ward, heirs, administrators, personal representatives or assigns, do agree to hold harmless, release, and discharge SGTP, their owners, agents, employees, volunteers, officers, directors and all others acting on their behalf, of and, from all claims, demands, causes of action and legal liability, whether the same be known or unknown, anticipated or unanticipated, due to SGTP's and their associates ordinary negligence, and I do further agree that except in the event of SGTP's gross negligence and willful and wanton misconduct, I shall not bring any claims, demands, legal actions and causes of action, against this stable and its associates as stated above in this clause, or any economic and non-economic losses due to bodily injury, death, property damage, sustained by me and /or my minor child and/or legal ward in relation to the premises and operations of this control of SGTP, whether on or off the premises of this stable.

WARNING

Under North Carolina Law, an equine activity sponsor or equine professional is not liable for an injury to or the death of a participant in equine activities resulting exclusively from the inherent risks of equine activities. Chapter 99E of the North Carolina General Statutes.

I/WE, THE UNDERSIGNED, HAVE READ AND UNDERSTAND THE FOREGOING AGREEMENT, WARNINGS, RELEASE , AND ASSUMPTION OF RISK.

_____ _____

Signature of Participant Date

_____

Home Phone **Business Phone** **Mobile Phone** **Email address**

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Date: _____

Dear Health Care Provider:
Your patient, _____
(participant's name)
is interested in participating in supervised equine activities with Saving Grace Therapeutic Programs. In order to safely provide this service, our center requests that you complete/update the attached Medical History and Physician's Statement Form. **Please note that the following conditions may suggest precautions and contraindications to equine activities.** Therefore, when completing this form, please note whether these conditions are present, and to what degree.

Orthopedic
Atlantoaxial Instability - include neurologic symptoms
Coxarthrosis
Cranial Defects
Heterotopic Ossification/Myositis Ossificans
Joint subluxation/dislocation
Osteoporosis
Pathologic Fractures
Spinal Joint Fusion/Fixation
Spinal Joint Instability/Abnormalities

Neurologic
Hydrocephalus/Shunt
Seizure
Spina Bifida/Chiari II malformation/Tethered Cord/Hydromyelia

Other
Indwelling Catheters/Medical Equipment
Medications - i.e. photosensitivity
Poor Endurance
Skin Breakdown

Medical/Psychological
Allergies
Animal Abuse
Cardiac Condition
Physical/Sexual/Emotional Abuse
Blood Pressure Control
Dangerous to self or others
Exacerbations of medical conditions (i.e. RA, MS)
Fire Settings
Hemophilia
Medical Instability
Migraine
PVD
Respiratory Compromise
Recent Surgeries
Substance Abuse
Thought Control Disorders
Weight Control Disorder

Thank you very much for your assistance. If you have any questions or concerns regarding this patient's participation in equine assisted activities, please feel free to contact the center at the address/phone indicated above.

Sincerely,
Janna Griggs, Executive Director

Participant's Medical History & Physician's Statement

(to be completed by a licensed physician)

Please fill this out to its fullest extent

Participant: _____ DOB: _____
Diagnosis: _____ Date of Onset: _____
Past/Prospective Surgeries: _____
Medications: _____
Seizure Type: _____ Controlled: Y N Date of Last Seizure: _____
Shunt Present: Y N Date of last revision: _____
Special Precautions/Needs: _____
Mobility: Independent Ambulation Y N Assisted Ambulation Y N Wheelchair Y N
Braces/Assistive Devices: _____

Please indicate current or past special needs in the following systems/areas, including surgeries which could potentially be a contraindication to horseback riding.

	Y	N	Comments
Auditory			
Visual			
Tactile Sensation			
Speech			
Cardiac			
Circulatory			
Integumentary/Skin			
Immunity			
Pulmonary			
Neurologic			
Muscular			
Balance			
Orthopedic			
Allergies			
Learning Disability			
Cognitive			
Emotional/Psychological			
Pain			
Other			

Given the above diagnosis and medical information, this person is not medically precluded from participation in equine-assisted activities and/or therapies. I understand that the Saving Grace Therapeutic Program staff will weigh the medical information given against the existing precautions and contraindications. Therefore, I refer this person to the organization for ongoing evaluation to determine eligibility for participation.

Name/Title: _____ MD DO NP PA Other _____

Signature: _____ **Date**: _____

Address: _____

Phone: (____)_____ License/UPIN Number: _____