

ELIGIBILITY STATEMENT POLICY: - The Achievement Centers for Children's Horsemanship Program (ACC) serves individuals ages 4 and over, with and without disabilities. The ACC has established maximum weight and physical ability guidelines for riding to promote the safety of the client, the safety of volunteer side walkers, and the well-being of the horses. Upon receipt of this application and the \$35.00 application fee, an intake/riding assessment will be scheduled to determine the skill level and/or suitability of the program.

PAYMENT and CANCELLATION POLICY: - Payment in full is due per schedule below. All third-party payers or outside funding sources must have written authorization in place prior to attendance. The client/family is financially responsible for all program costs not covered by third-party payers. Cancellation must be made in writing two weeks prior to withdrawal from program to avoid a \$70.00 (2 class) penalty. Once the session has started, there are no credits/refunds for cancelled or missed classes (including for illness) with the exception for medical emergencies. Signed/dated documentation from a licensed physician must be provided for all medical emergency excuses. **Accounts that are past due will have services suspended until payment is current.**

Please check below to indicate your form of payment:

***Pay in full \$350.00 or follow payment plan below**

- _____ Self Pay
- _____ NEON/Family Support
- _____ MCCD
- _____ Other grant/funding source below

SESSION DATES	FEES - \$350 PAY IN FULL or
January 6 – March 14 (10 week session)	\$175 DUE BY 12/30/19 \$175 DUE BY 2/4/20
March 16 – May 23 (10 week session)	\$175 DUE BY 3/9/20 \$175 DUE BY 4/14/20
May 25 – August 1 (10 week session)	\$175 DUE BY 5/18/20 \$175 DUE BY 6/23/20
August 3 – October 10 (10 week session)	\$175 DUE BY 7/27/20 \$175 DUE BY 9/1/20
October 12 – December 19 (10 week session)	\$175 DUE BY 10/5/20 \$175 DUE BY 11/10/20

Goals for participation: _____

Does the client have a Behavior Plan? YES NO
 Does the client have an IEP? YES NO

If yes please provide a copy.

Foster Care - If client is in foster care, please complete. County that holds custody: _____

Case worker name: _____ Phone #: _____

Achievement Centers for Children Services

Check here if interested in receiving services and/or information about Outpatient Rehabilitation Services offered through the Achievement Centers for Children. Circle all that apply:

Occupational Therapy Physical Therapy Speech Therapy Mental Health

Please sign below signifying that you have read and are in agreement with the terms & conditions listed in the application. If the application is not signed, it will not be processed.

Parent/Guardian/Client Signature

Date

Return application packet to:

Camp Cheerful
Attn: Cory Ramsey
15000 Cheerful Lane
Strongsville, OH 44136

Please direct any questions regarding the application process to (440) 238-6200 ext.225



The Achievement Centers for Children RECREATIONAL PROGRAMS Client Informational Form

Client Name _____

GENERAL INFORMATION FOR ALL RECREATIONAL PROGRAMS

Primary Disability _____ No Disability

Secondary Disability (if applicable) _____

School or workshop currently attending _____ Grade _____ Age _____

Enrolled in special class? YES or NO What type? _____

Enrolled in therapy? YES or NO What type? _____

PERSONAL HISTORY:

Have there been changes in **health or behavior** over the past year? YES NO

If yes, please explain _____

SUPERVISION:

Does the client have a 1:1 aide at home? YES NO

Does the client ever need 2:1 assistance? YES NO

Does the client need additional assistance when in the community? YES NO

What level of supervision is required? Always within reach Always within sight Allowed "alone time"

If you answered yes to any of the questions above, please explain _____

SPECIAL CONCERNS: Please check all that apply

- Shyness
- Divorced or separated parents
- Afraid of Heights
- Physical activity must be monitored or restricted (Explain) _____

None/no special concerns

SOCIAL CONCERNS: Please check all that apply

- Reacts to frustration
 - Does not like group participation
 - Has poor peer relationships
 - Does not like supervision or authority
 - None/no concerns
- Explain _____

What would you like your camper to work on or improve? _____

LANGUAGE AND COMMUNICATION: Please check all that apply

- Uses sign language
- Uses Communication Device
- Picture exchange
- Has difficulty speaking
- Has difficulty being understood
- Understands verbal instructions
- Has no communication needs

Please describe special words and phrases used at home that would be helpful for communication: _____

EQUIPMENT: Please check all that apply

- Able to walk alone
- Uses crutches or cane
- Uses walker
- Uses wheelchair/manual
___ full day ___ ½ day
- Needs assistance pushing wheelchair
- Uses wheelchair/power
___ full day ___ ½ day
- Can transfer from wheelchair independently
- AFO's/Braces
___ full day ___ ½ day
- PE Tubes
- Eyeglasses
- Uses hearing aid
- None/no equipment

Will any other equipment accompany client to the program? YES or NO Explain

COORDINATION CONCERNS: Please explain _____

SENSORY ISSUES: Please check all that apply

- Tactile/Touch
- Auditory/Sound
- Visual
- Balance
- Clumsiness
- None/No sensory concerns

Explain sensory concerns, calming techniques, and/or strategies:

BEHAVIORS: Has client ever displayed the following? Please check a response for each:

- | | | | |
|------------------------------------|-------------------------------|----------------------------|-----------------------------|
| Hitting | <input type="radio"/> Current | <input type="radio"/> Past | <input type="radio"/> Never |
| Pinching | <input type="radio"/> Current | <input type="radio"/> Past | <input type="radio"/> Never |
| Hair Pulling | <input type="radio"/> Current | <input type="radio"/> Past | <input type="radio"/> Never |
| Biting | <input type="radio"/> Current | <input type="radio"/> Past | <input type="radio"/> Never |
| Kicking | <input type="radio"/> Current | <input type="radio"/> Past | <input type="radio"/> Never |
| Spitting | <input type="radio"/> Current | <input type="radio"/> Past | <input type="radio"/> Never |
| Scratching | <input type="radio"/> Current | <input type="radio"/> Past | <input type="radio"/> Never |
| Bullying | <input type="radio"/> Current | <input type="radio"/> Past | <input type="radio"/> Never |
| Stealing | <input type="radio"/> Current | <input type="radio"/> Past | <input type="radio"/> Never |
| Lying | <input type="radio"/> Current | <input type="radio"/> Past | <input type="radio"/> Never |
| Swearing | <input type="radio"/> Current | <input type="radio"/> Past | <input type="radio"/> Never |
| Wandering | <input type="radio"/> Current | <input type="radio"/> Past | <input type="radio"/> Never |
| Runs Away | <input type="radio"/> Current | <input type="radio"/> Past | <input type="radio"/> Never |
| Withdrawal | <input type="radio"/> Current | <input type="radio"/> Past | <input type="radio"/> Never |
| Impulsivity | <input type="radio"/> Current | <input type="radio"/> Past | <input type="radio"/> Never |
| Non-compliance | <input type="radio"/> Current | <input type="radio"/> Past | <input type="radio"/> Never |
| Mood Swings | <input type="radio"/> Current | <input type="radio"/> Past | <input type="radio"/> Never |
| Verbal Threats | <input type="radio"/> Current | <input type="radio"/> Past | <input type="radio"/> Never |
| Throwing Objects | <input type="radio"/> Current | <input type="radio"/> Past | <input type="radio"/> Never |
| Oral Stimulation (biting, chewing) | <input type="radio"/> Current | <input type="radio"/> Past | <input type="radio"/> Never |
| Hand Flapping | <input type="radio"/> Current | <input type="radio"/> Past | <input type="radio"/> Never |
| Head Banging | <input type="radio"/> Current | <input type="radio"/> Past | <input type="radio"/> Never |
| Rocking | <input type="radio"/> Current | <input type="radio"/> Past | <input type="radio"/> Never |
| Inflicts self injury | <input type="radio"/> Current | <input type="radio"/> Past | <input type="radio"/> Never |
| Disrobing | <input type="radio"/> Current | <input type="radio"/> Past | <input type="radio"/> Never |
| Anxiety/depression | <input type="radio"/> Current | <input type="radio"/> Past | <input type="radio"/> Never |
| Sexual acting out | <input type="radio"/> Current | <input type="radio"/> Past | <input type="radio"/> Never |
| Genital stimulation | <input type="radio"/> Current | <input type="radio"/> Past | <input type="radio"/> Never |
| Suicidal Ideation | <input type="radio"/> Current | <input type="radio"/> Past | <input type="radio"/> Never |
| Enuresis (urination accidents) | <input type="radio"/> Current | <input type="radio"/> Past | <input type="radio"/> Never |
| Encopresis (bowel accidents) | <input type="radio"/> Current | <input type="radio"/> Past | <input type="radio"/> Never |

Please describe any behaviors, behavior strategies, or key phrases: _____

Please describe any rewards/motivators that can be used at camp to keep camper focused: _____

SPECIAL INTERESTS OR SKILLS _____

FOR CLIENTS ATTENDING WEEKEND RESPITE or RESIDENT CAMP PROGRAMS ONLY

Has client ever attended an overnight camp before? YES NO

Where and When _____

HYGIENE:

Does camper need assistance brushing teeth? YES NO

Does camper need assistance showering? YES NO

Does camper avoid showering, bathing or brushing teeth? YES NO

If you answered **yes** to any of the above questions, please provide suggestions of special techniques used at home

SLEEPING HABITS: Please check all that apply

- Sleep walks (where, how long, etc.)
- Needs special positioning (explain)
- Needs to be turned (how often)
- Wets bed (how is it handled)
- Talks in sleep/snores
- No sleeping concerns
- Other sleeping concerns (explain)

Please check one:

- Bunk Bed – Top bunk
- Bunk Bed – Bottom bunk
- Hospital Bed

Music at night YES NO

Night-light YES NO

Please provide any necessary description or explanation for the items you checked on the above questions _____

SPECIAL CONCERNS: Please check all that apply

- First time away from home
- Homesickness
- Fears _____

FOR CLIENTS ATTENDING DAY CAMP or RESIDENT CAMP or PARTICIPATING IN THERAPEUTIC HORSEMANSHIP

Weight: _____ **Height:** _____

TRUNK CONTROL: Please check all that apply

- Sits up on own
- Hypertonic movement (High tone – rigid/tight muscle movement)
- Hypotonic movement (Low tone – loose flexibility)

Has client ever attended a therapeutic riding program before? YES NO

Where and When _____

The Achievement Centers for Children has established maximum weight and physical ability guidelines for Therapeutic Riding to ensure the safety of the client, the safety of volunteer side walkers, and the well-being of the horses. The Achievement Centers for Children will evaluate all participants in accordance with these guidelines.

FOR CLIENTS ATTENDING WEEKEND RESPITE, RESIDENT CAMP, DAY CAMP, CHAMP CAMP or SENSATIONAL DAY PROGRAM

EATING HABITS: Please check all that apply

- Needs to be fed
- Needs food cut
- Needs food blended
- Needs help drinking (special cup, straw, etc.)
- Difficulty swallowing (how is it handled)
- Special positioning (explain)
- Special equipment (explain how to use)
- Special diet or food restrictions (explain)
- Food allergies (what food and how is it handled)
- Eats independently/No concerns

What percentage of their meal do they usually consume ____100% ____75% ____50% ____25%

Please provide any necessary description or explanation for the items you checked on the above questions _____

PERSONAL CARE:

- Does camper need toilet reminders? YES NO
- Does camper need lifted onto the toilet? YES NO
- Does camper have bowel control? YES NO
- Does camper need assistance with personal hygiene? YES NO
- Does camper have constipation problems? YES NO
- Does camper have bladder control? YES NO
- Does camper have a catheter? YES NO

If yes, camper can self-catheter OR camper needs assistance with catheter

What personal care supplies will camper bring to Camp? _____

Does camper dress independently? YES NO

HEALTH CONCERNS:

Does client have seizures? YES NO If yes, are they controlled? YES NO

List seizure medications: _____

Date of last seizure: _____ Please describe type, frequency, length, and strategies for dealing with seizures _____

Has camper been hospitalized in the last year? YES NO If yes, state reason _____

SWIMMING: Please check all that apply

- Must wear life jacket
- Swim only in shallow water
- Afraid of water

CAMP STORE:

Beverages – Camper can have _____ sodas per day - with caffeine without caffeine

Assistance drinking needs assistance does not need assistance

Snacks – Camper can have _____ servings of candy per day - hard candy yes no

PLEASE READ CAREFULLY: I give consent for myself or my child/client to participate in the activities of the Achievement Centers for Children's Camping and Recreational Programs.

Signature of Parent/Guardian/Client _____

Date _____

Camp Cheerful is operated by the Achievement Centers for Children and is accredited by the American Camp Association and PATH Intl. (Professional Association of Therapeutic Horsemanship International).



THE ACHIEVEMENT CENTERS FOR CHILDREN

Camp Cheerful Health History Report

Achievement Centers for Children

Client Name: _____

TB Test (recommended every two years, but not mandatory) Most recent test date: _____

Tetanus Shot: Yes _____ Date: _____ No _____

Allergies and/or dietary restrictions: (please list) _____

Does client have seizures: Yes _____ No _____ **If yes, are seizures controlled** Yes _____ No _____

Date of last seizure _____

Please describe type, frequency, length, strategies, etc. for dealing with seizures:

Client is free from communicable diseases: Yes _____ No _____

To my knowledge, there is nothing preventing my child from participating in supervised Adapted Sports, TR and/or camp activities.

Signature of parent/guardian completing form

Date

.....

THE FOLLOWING INFORMATION REQUIRED FOR DAY AND CHAMP CAMPERS ONLY

Indicate any restrictions with regard to Camp activities and any current physical, mental, or psychological conditions requiring medication, treatment or special restrictions at

Camp: _____

Record of past medical treatment, if any: _____

Current Medications: _____

Immunization Record (required for persons 18 years and younger)

Vaccine	First	Second	Third	Booster	Booster
DPT or DT					
Hib					
OPV					
MMR					
HBV					
Varicella					

Signature of parent/guardian completing form

Date

Printed name of parent/guardian completing form



THE ACHIEVEMENT CENTERS FOR CHILDREN
 Emergency Transportation Authorization
Part I (Authorization) OR Part II (Refusal) must be completed

AUTHORIZATION

Name _____ D.O.B. / / Soc. Sec. # _____
 Address _____
 Mother (if minor) _____ Father (if minor) _____
 Address _____

 Contact # _____ Contact # _____
 Language spoken at home: _____ Insurance provider/ member ID# _____

In the event of reasonable attempts to contact me at my contact phone number have been unsuccessful, I hereby give consent for
 1) the administration of any treatment deemed necessary by
 my preferred doctor, Dr. _____ phone # _____
 my preferred dentist, Dr. _____ phone # _____
 or, in the event that the designated practitioner is not available, by another physician or dentist; and,
 2) the transportation of myself/my child/my client to _____ Hospital, or to any hospital reasonably accessible.

In the event of an accident, injury or sudden illness, I give consent to and authorize The Achievement Centers for Children to summon a physician to perform medical treatment, transport to or request hospital admission or treatment billable to my insurance provider/member ID# as indicated previously and/or at my expense as may be necessary and for qualified personnel to perform necessary medical procedures.

This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained before surgery is performed.

Facts concerning the individual's medical history including allergies, medications being taken, and any physical impairments to which a physician should be alerted are noted on the Health History/ Physical Form.

Persons to be contacted in the event of an emergency if a parent/guardian cannot be reached (list two people):

Name	Name
Contact #	Contact #
Contact #	Contact #
Rel. to Client	Rel. to Client

ACCEPTANCE

Signed: _____ Rel. To Client _____ Date / / _____

REFUSAL

I do not give consent for emergency medical treatment. In the event of illness or injury requiring emergency medical treatment, I understand that The Achievement Centers for Children must nevertheless act in the interests of health and safety and may need to call emergency personnel. I request that such personnel take no action until I or my legal designee can be contacted directly. I further understand that this form will be transported with me/my child/my client.

Signed: _____ Rel. to Client _____ Date / / _____



Achievement Centers for Children Authorization for Photography and Related Information

(includes all electronic media – photography, videography, and voice recordings)

Printed Client Name: _____

PLEASE CHECK THE APPROPRIATE BOX BELOW:

YES, I give authorization to the Achievement Centers for Children (ACC) to use my/my child's name, likeness, voice, photograph, demographic, and diagnosis and related information in any print media, online use, advertising and publicity media, including audio recordings, television, radio, and video, social media and websites, without limitations or reservations. All such materials shall be the exclusive property of the Achievement Centers for Children now and in the future.

I release ACC, its personnel and any other persons making or handling the records from any liability.

I understand that I have the right to revoke/withdraw this authorization at any time in writing with my signature and giving it to the Development Department of the Achievement Centers for Children. My revocation/withdrawal will be effective except to the extent that ACC has taken action in reliance on my authorization.

NO, I do **NOT** give authorization to use my/my child's name, likeness, voice, photograph, demographic information, diagnosis and related information in print or non-print materials.

Date: _____

Printed Client/Parent/Guardian's Name

Signature

Relationship to Client (mother, father, guardian, etc.)

Home Phone _____

Cell Phone _____

Email Address _____



Achievement Centers for Children

THE ACHIEVEMENT CENTERS FOR CHILDREN
Camp Cheerful
Authorization to Release Client

Do you give authorization to release client _____
(please print client name)

to someone other than a parent or guardian?

No

Yes

Please sign and return this form. If you responded yes, you must also complete the information below.

I, (please print name) _____, parent/guardian of the above named client, authorize the Achievement Centers for Children to release the above client to the individuals listed below for the purpose of being able to pick up in the event that I am unable to do so.

I understand that the individuals listed must be at least 18 years of age and may be asked for a picture identification by any staff at any time before the client will be released. I understand and agree that staff may refuse to authorize a release, if in their best professional judgment, circumstances warrant such refusal.

	<u>Name</u>	<u>Phone number</u>	<u>Relationship to Client</u>
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____

I understand this authorization expires 360 days from the date it is signed unless otherwise indicated by me. I also understand that I may cancel this release at any time in writing with my signature, and the date it is signed, and deliver it to the Quality Assurance Manager/Privacy Officer. Canceling applies to that day forward and not to past occurrences.

Signed: _____ Date ___/___/___

Relationship to Client _____



ACHIEVEMENT CENTERS FOR CHILDREN

AUTHORIZATION FOR RELEASE OF INFORMATION

Form Expires on _____

Client's Full Name _____ Date of Birth _____

Social Security Number _____ Individual Case Number (optional) _____

The following persons/programs/agencies have my permission to coordinate service planning and delivery for the above named person by disclosing specific information for the following specific purpose (s):
service coordination, assessment, treatment, and planning only with Achievement Centers for Children staff

Please identify all persons/programs/agencies that may disclose to and/or receive information.

- Achievement Centers for Children Team _____
- _____ _____
- _____ _____
- _____ _____

I authorize the release of the specific information for which I have circled and initialed below only if it is necessary to secure or coordinate needed services identified in my case plan by the persons/programs/agencies identified above:

Circle yes and initial

- yes _____ Identifying information: name, birth date, sex, race, address and telephone number.
- yes _____ Social Security Number
- yes _____ General Medical: medical records (except for HIV, AIDS and drug and alcohol treatment records) disability, type of services being received and name of agency providing services to me or the individual named above.
- yes _____ Social History: social history, treatment/service history, psychological evaluations and other personal information regarding the individual named above or me.
- yes _____ School Information: grades, attendance records, Individualized Education Plan (IEP), Individualized Family Service Plan (IFSP), Individualized Service Plan (ISP), Multi-Factored Evaluation (MFE), (Children's) Ohio Eligibility Determination Instrument (COEDI/OEDI), transition plans and vocational assessments regarding me or the individual named above.
- yes _____ HIV and AIDS related diagnosis and treatment.
- yes _____ Current substance abuse treatment, recommendations and involvement specifically, _____
- yes _____ Financial Information necessary to establish eligibility for public assistance including but not limited to pay stubs, W2's and tax returns, and other financial information.
- yes _____ Other _____

Revised 2/03 / 1821; revised 2/11; 1/13

SIGNATURE REQUIRED

I understand that my alcohol and drug abuse patient records are protected under the Federal regulations governing confidentiality of those records, (42 CFR Part 2), cannot be disclosed without my written consent unless otherwise provided for in the regulations. I understand that I may inspect or copy the protected health information to be used or disclosed. I understand this Release expires 180 days from the date it is signed unless otherwise indicated by me. I also understand that I may cancel this Release at any time in writing with my signature, and the date it is signed, and delivering it to the Director of Quality Assurance/Privacy Officer. Canceling it applies to that day forward and not to information already shared.

I understand that signing or refusing to sign this Release will not affect public benefits or services for which I am eligible, unless otherwise required by the regulations of the agency.

I understand that the information disclosed pursuant to this authorization may be the subject of re-disclosure by the recipient without further protection.

If not previously revoked, this consent expires on the _____ day of _____, 20_____.

Client Signature

Date

Parent/Guardian Signature

Date

Witness/Agency Representative

Date

Violation of Federal law and regulations by a program is a crime. Suspected violations may be reported to the United States Attorney in the district where the violation occurs.

TO ALL AGENCIES SENDING AND/OR RECEIVING INFORMATION DISCLOSED AS A RESULT OF THIS SIGNED CONSENT:

1. If the records released include information of any diagnosis or treatment of drug or alcohol abuse, the following statement applies:

**PROHIBITION ON REDISCLOSURE OF INFORMATION
CONCERNING CLIENT IN ALCOHOL OR DRUG ABUSE TREATMENT**

This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

2. If the records released include information of an HIV-related diagnosis or test results, the following statement applies:

This information has been disclosed to you from confidential records protected from disclosure by state law. You shall make no further disclosure of this information without the specific, written and informed release of the individual to whom it pertains, or as otherwise permitted by state law. A general authorization for the release of medical or other information is NOT sufficient for the purpose of the release of HIV test results or diagnoses.

3. The information has been disclosed to you from records protected by federal and/or state confidentiality rules. Any further release of it is prohibited unless the further disclosure is expressly permitted by the person to whom it pertains, Juvenile Court/DYS in the case of youth records, or applicable federal and/or state law.



THE ACHIEVEMENT CENTERS FOR CHILDREN
CAMP CHEERFUL

THERAPEUTIC HORSEMANSHIP PROGRAM
ATTENDANCE POLICY

Consistent attendance and on-time arrival is important for the participant to maximize the benefit of the services. Instructors have daily lesson plans and volunteers have the horses ready for your participation.

Cancellations

If you cannot attend your scheduled lesson, it is your responsibility to call and cancel as soon as you are aware that the rider will be absent or **at least 2 hours** prior to your scheduled ride time, in order to be eligible for a make-up.

- **Only one make-up lesson per session** will be permitted.
- There will be **no refunds for missed lessons** without a medical excuse.

To cancel a lesson, please call (440) 238-6200 ext. 255. This is a voice-mail only extension and is checked periodically during the day. Please leave the following information:

- Name of participant canceling the lesson
- The day and time of the lesson that you are canceling
- The reason you are canceling
- A phone number where you can be reached

On-Time Arrival

Please arrive to your lesson 5 to 10 minutes prior to your scheduled time. Riders arriving late can be a distraction to the other riders and affect the planned activity for the class. **Anyone arriving 15 or more minutes late to their scheduled class time WILL NOT BE ALLOWED TO PARTICIPATE and will be charged for that lesson.**

Medical Absences

Refunds for missed lessons will be granted with a medical excuse. Riders returning from missed lessons due to medical reasons such as sprains, surgeries, etc. must obtain a Therapeutic Horsemanship Medical Release Form signed by a physician in order to return to riding. To obtain this form please contact Cory Ramsey at 440-238-6200 x225.

CLIENT AGREEMENT

I understand and agree to follow the above policies/procedures. I also understand that there are no refunds for unexcused absences and there are no guarantees that my missed lesson will be rescheduled.

Print Client Name

Client/Parent/Guardian Signature

Date



EQUINE ACTIVITY RELEASE, WAIVER, AND ASSUMPTION OF RISK AGREEMENT

This Equine Activity Release, Waiver, and Assumption of Risk Agreement ("Equine Activity Agreement") is given under the Ohio Equine Activity Liability Act, Ohio Revised Code Section 2305.321 (the "Act"). The undersigned, on his or her own behalf, and on behalf of any minor or mentally disabled adult named below, and on behalf of their respective heirs, assigns, successors, executors, administrators, and legal representatives, does hereby release, acquit and discharge Achievement Centers for Children, and its officers, directors, employees, representatives, volunteers, servants, staff, agents, heirs, successors and assigns, including any "equine professional" as defined by the Act ("Achievement Centers"), from and against any and all claims, claims for relief, actions, causes of action, liabilities, injuries, damages, demands, rights, losses, costs, interest, expenses, including attorney fees, of any kind, description or nature whatsoever, whether arising out of contract, tort, statute or otherwise, in law or in equity, that arise from or relate in any manner to the participation in or presence at equine activities by Achievement Centers within the State of Ohio by the undersigned and by any minor or mentally disabled adult participant named below ("Loss"). The undersigned agrees and acknowledges that this Equine Activity Agreement is applicable regardless of whether any Loss, injury or death results from the negligence of the Achievement Centers, or from any other cause and hereby warrants and represents that he or she is in fact the legal parent or guardian of any minor or mentally disabled adult participant named below, with full rights of custody and control, has the authority to sign this Equine Activity Agreement on behalf of any such minor or mentally disabled adult participant, and consents to any such minor's or mentally disabled adult's presence and participation in equine activities at the Property.

The undersigned acknowledges that this Equine Activity Agreement is given on behalf of and is binding upon the undersigned, and also on behalf of and is binding upon any such minor or mentally disabled adult participant named below and their respective heirs, executors, administrators, personal representatives, successors and assigns; and the undersigned agrees that this Equine Activity Agreement is fully binding on the undersigned as if it were entered into solely on his or her own behalf. The undersigned hereby acknowledges that he or she has full and complete notice and understanding of all the risks, known and unknown, inherent in equine activities, and that these risks cannot be eliminated, altered or controlled regardless of the care used, the skill or experience possessed, or the precautions taken (in each case if any), by anyone; that these risks may cause, contribute to, or result in the death, physical injury, psychological injury, emotional/mental injury, or disability of the undersigned and of any minor or mentally disabled adult participant named below or damage to the participant's property or financial loss otherwise (the "Risks"), including, but not limited to: (a) the propensity of an equine to behave in ways, including dangerous, unpredictable and potentially uncontrollable ways, that may result in injury, death, or loss to persons on or around the equine; (b) the unpredictability of an equine's reaction to sounds, weather, environment, surroundings, sudden or other movement, familiar or unfamiliar objects, persons, or other animals; (c) hazards, including, but not limited to, surface or subsurface conditions including, for example, obstructed or uneven surfaces or conditions that could cause the participant or equine to trip or fall; (d) a collision or contact with another equine, another animal, a person, or an object; (e) misuse or failure of tack, gear and equipment; (f) the potential of an equine activity participant or other person(s) to act in a negligent manner or otherwise that may contribute to injury, death or loss to the person or property of the participant or to other persons, including, but not limited to, failing to maintain control over an equine; (g) exposure to mold, allergens, bacteria, toxins, viruses, disease; and (h) exposure to uncontrollable elements, such as, for example, heat, humidity, cold, wind, and rain.

The undersigned acknowledges that he or she is in the best position to understand and evaluate any added risk caused by any disability, limitation, illness, or condition of the undersigned or of any minor or mentally disabled adult participant named below, Although the undersigned is aware of the nature and extent of the Risks, he or she expressly accepts and assumes all risks of bodily injury, psychological injury, emotional/mental injury, disability, and/or death, and any property damage or other physical or financial loss that may occur as a result of the participation in equine activities by the undersigned or by any minor or mentally disabled adult participant named below. This Equine Activity Agreement is given on specific consideration of the permission granted by the Achievement Centers to the undersigned, and to any minor or mentally disabled adult participant named below, to participate in equine activities. The undersigned agrees to indemnify and save the Achievement Centers harmless from any and all judgments, damages, or expenses associated with any claims, demands, or lawsuits made against the Achievement Centers, by or on behalf of any person, that may arise as a result of the presence at or participation in equine activities by the undersigned, and by any minor or mentally disabled adult participant named below. The undersigned, on his or her own behalf, and on behalf of any minor or mentally disabled adult named below, authorize and consent to any first aid or emergency medical care which may be administered as deemed necessary or appropriate, due to injury or sickness caused by or incurred in the course of any equine activity. To the extent possible, this Equine Activity Agreement shall be construed in such manner as will render each provision fully enforceable; but if any provision of this Equine Activity Agreement shall be unenforceable, such provision (or so much thereof as is unenforceable) shall be deleted and the remainder of this Equine Activity Agreement shall continue in full force and effect. The undersigned states that he or she knowingly and voluntarily executed this Equine Activity Agreement and asserts that he or she understands all the terms used herein and the consequences thereof and acknowledges that this Equine Activity Agreement is binding upon the heirs, administrators, executors, representatives, successors and assigns of the undersigned and of any minor or adult with a developmental disability named below. This Equine Activity Agreement shall remain valid until released in writing by the undersigned.

Signed this _____ day of _____, 20_____.

Name of participant

Date of birth

Signature of participant

Parent/Guardian signature (if participant is a minor or an adult with a developmental disability)

CLEV1997 2285041v1 17999.00078



Acknowledgement of Agency Forms and Policies

You must sign below and return this form signifying that you have read and understand the policies and forms that were received in the attached policy acknowledgement packet.

- **PAYMENT and CANCELLATION POLICY**
 - payment must be received prior to attendance
 - cancellation policies will be strictly enforced
- **Miscellaneous Policies**
 - Lost and Found Policy
 - Acts of Nature
 - Horsemanship Policies
- Clients Rights and Responsibilities
- Privacy Policy
- Achievement Centers for Children Agency Handbook

If you have any questions regarding the policies listed above, please be in contact with an Achievement Centers for Children Recreational staff member.

This form is mandatory to complete the registration process. Clients cannot participate in any recreational program without this form on file. This form must be forwarded to the camp office.

Client Name (Print)

Client/Parent/Guardian Signature

Date