The Pilot House
Special Needs Center

MEMBERSHIP FORM

Please fill out this form completely so we can process your membership. All information provided will be for the private use of The Pilot House and will not be shared with any third parties.

Family Membership

Parent/Guardian Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone number: _____ Cell phone: _____

Email _____ (Email is our primary form of communication with the membership)

Child/Children

Name_____ D.O.B._____ Age_____
Name_____ D.O.B._____ Age_____
Name_____ D.O.B._____ Age_____
Name_____ D.O.B._____ Age_____

Educator/ Service provider Membership

Name: _____

Profession: _____

Address_____

City: _____ State: _____ Zip Code: _____

Email: _____ (email is our primary form of communication with the membership.)

Annual Membership fee $125 (July1st – June30th)

Please send to:
The Pilot House
240 Colony Street
Fairfield, CT 06824

HOPE
RIVER FARM

RIDING PROGRAM WAIVER

Name of Student: _____ DOB: _____ Gender: Male/Female

Parent/Legal Guardian: _____

Address: _____

Home Phone: _____ Cell Phone: _____

Email: _____

Waiver

I am requesting that I/my child/my ward, have the opportunity to participate in Equine Assisted Activities and Therapies, including the Therapeutic Riding Program at Hope River Farm, and I understand that my/my child's/my ward's participation in that program will involve riding and being in close proximity to horses. I recognize that there are inherent risks of injury involved with horseback riding. In participating in the program, I agree to assume the risk that I/my child/my ward may be injured and/or there may be injury to my/my child's/my ward's property. To the fullest extent permitted by law, I do hereby, for myself/my child/my ward, my/my child's/my ward's heirs and executors, waive and release forever and discharge any and all claims for damages to persons or property which I/my child/my ward may have or which hereafter may accrue to me/my child/my ward against The Pilot House, its employees, agents, volunteers, leaders and/or medical staff, for any/all claims arising or growing out of my/my child's/my ward's participation in the program, including but not limited to claims which may arise out of my own/my child's/my ward's negligence or the negligence of The Pilot House employees/ Hope River Farm agents, volunteers, leaders and/or medical staff, and I agree to indemnify and hold harmless The Pilot House/Hope River Farm, its employees, agents, volunteers, leaders and/or medical staff on account of any such claim.

DO NOT sign until this waiver has been read and fully understood.

Signature:_____ Date: _____

Print Name:_____ Relationship: ☐Self ☐Parent ☐Guardian

Photo/Media Release for Minors

I, being the parent/legal guardian of _____, hereby consent that his or her name, image and likeness, as shown in of any and all photographs and audio/visual materials; and quotations may be used by The Pilot House/Hope River Farm to promote programs and activities in print and electronic form. This may include, but is not limited to, press releases to the media, newsletters, fundraising materials, social media platforms, and our website.

Signature:_____ Date: _____

Photo/Media Release for Adults

I, _____, being of legal age, hereby consent that my name, image and likeness, as shown in of any and all photographs and audio/visual materials; and quotations may be used by The Pilot House/Hope River Farm to promote programs and activities for the benefit of the program. This may include, but is not limited to, press releases to the media, newsletters, fundraising materials, social media platforms, and our website.

Signature:_____ Date: _____

Emergency Medical Release

In case of an emergency, I _____, hereby authorize The Pilot House/Hope River Farm and/or a currently certified First Aider, to give necessary first aid and/or CPR to myself, or my child _____, and I also authorize the person in charge to obtain and consent to, on my behalf, whatever medical diagnosis treatment is deemed necessary or advisable by such person for the well-being of myself, or my child.

Signature:_____ Date: _____

HOPE
RIVER FARM

MEDICAL RELEASE FORM

Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Email: _____

Height: _____ Weight: _____ DOB: _____ Gender: Male/Female

Parent/Guardian _____

Parent/Guardian Contact Info
(If different from above)

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Email _____

The Pilot House/Hope River Farm Equestrian Program provides equine assisted activities and therapies designed to improve physical, mental, cognitive, social and emotional well being. The Program is overseen by a Professional Association of Therapeutic Horsemanship International, (PATH) certified instructor with the help of trained volunteers.

The Pilot House/Hope River Farm Equestrian Program provides horses, safety belts and other equipment as required per each rider. RIDERS MUST PURCHASE THEIR OWN ASTM-SEI CERTIFIED EQUESTRIAN HELMET and riding boots. In order to insure the fullest possible protection and greatest personal benefit from the program, each applicant is required to furnish the following medical information before being accepted as a rider

Note: No individual diagnosed with Down's Syndrome can be accepted into The Program without proof of a negative diagnostic X-Ray for Atlantoaxial Dislocation Condition.

PHYSICIAN'S AUTHORIZATION

Diagnosis: _____ Date of Onset: _____

Condition: _____

Medical History

_____

_____

Surgical Procedures: _____

Date of last physical exam: _____ Date of last Tetanus: _____

Medications: Please note what condition each medication is for, dose and frequency.

_____

_____

Psychological: Include IQ where pertinent; as well as phobias (i.e. heights).

_____

_____

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

Sight_____

Hearing_____

Speech _____

Neuro-sensation _____

Circulation _____

Muscular_____

Coordination /Balance _____

Mobility _____

Heart_____

Breathing_____

Bone/Joint_____

Allergies_____

Are braces or other assistive devices used? Yes / No

If yes, please describe: _____

_____

Incontinence: _____ Ambulatory: Yes / No

Limitations – please describe:

_____

_____

Recommendations:

_____

_____

In my opinion, this person can receive riding instruction under appropriate supervision. In conjunction with equine assisted activities and therapies (EAAT), I concur in the referral of the participant to the staff physical therapist for evaluation of his or her physical abilities and/or limitations in performing exercises.

Precautions or Contraindications for participation in EAAT:

_____

_____

Please attach any information deemed pertinent to participation in The Program. Thank you.

Physician's Signature: _____ Date: _____

Print Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Email: _____

Physician stamp: