ANIMALS AS NATURAL THERAPY

Participant Registration & Release

Name:	Age:	Pronouns:
Date of Birth:	Jacket Size:	Shoe Size:
Street Address:	City:	
State:	Zip Code:	
Primary Caretaker:	Phone:	
Relationship to participant:	Email address:	
Address/Phone if different from above		
School attending:		
Were you referred by a counselor? Yes ☐ No ☐	Name:	
How did you hear about ANT?		

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 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 my child 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:

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 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

I **DO NOT** 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 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:	Age:
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:

Natural Disasters Parking Protocol

In case of natural disaster (fire or earthquake), please park along Kline Rd. to allow emergency vehicles the right of way into our one-way driveway. You will be contacted by ANT staff with where to meet to pick up your youth.

I understand the emergency protocol:

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 themselves or are in a dangerous situation. 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 or have been harmed themself 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 ANT's 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.

g) ANT staff meets regularly with other appropriate professionals for consultation in order to improve our ability to be effective professionals. Periodically, we consult with other providers regarding issues specific to you or your child. When consulting with other professionals outside of Animals as Natural Therapy, no names of the client(s) are used in order to protect confidentiality, unless we have written consent of those clients or guardians.

h) Animals as Natural Therapy's Licensed Mental Health Clinicians and Mental Health Interns present client sessions and consult regularly with their Clinical Supervisor for clinical support. This Clinical Supervisor is bound by the same confidentiality rules as your mental health provider. Clinicians also occasionally share session information with the Mental Health team to ensure we are providing the highest level of care possible. Counseling interns may also be required to present client sessions for review with their graduate institution for educational purposes.

Date: _____ Signature:_____

Participant, Parent or Guardian

Participant's Medical History

Full Name:	
Any known allergies:	Date of last tetanus:
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 ensure 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?	☐	☐
2. Chronic recurring illness/condition?	☐	☐
3. Frequent headaches?	☐	☐
4. Ever had head injury?	☐	☐
5. Wear glasses, contacts, or protective eyewear?	☐	☐
6. Use mobility device(s) or hearing aids?	☐	☐
7. Ever passed out during or after exercise?	☐	☐
8. Ever had seizures?	☐	☐
9. Chest pain during or after exercise?	☐	☐
10. High blood pressure?	☐	☐
11. Back problems?	☐	☐
12. Joint problems (e.g., knees, ankles)?	☐	☐
13. Orthodontic appliance or headgear being used?	☐	☐
14. Any skin problems (e.g., allergies, rash, hives)?	☐	☐
15. Diabetic?	☐	☐
16. Asthmatic?	☐	☐
17. Short or long-term memory impairment?	☐	☐
18. Tendencies toward emotional/violent outburst or inflicting harm to self, others or animals? Please specify.	☐	☐

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

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

Check if 'Yes':

- 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

Racial/Ethnic Group

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

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 program 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

Charges for ANT's EAL sessions are $100 per 90-minute group session. This is $900 per 9-week quarter, with **payment in full due by the end of the quarter.** Private EAP sessions (with a therapist present) are $175 for 60-minutes, payment is due at time of session. Monthly statements will be sent to reflect the total amount due for the quarter. This statement will also show any financial assistance granted.

Limited partial 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:

- Staff and 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 24 hours in advance** if your child will be absent. Your child is considered "unexcused" if notice is given less than 24 hours prior to their session time. Exceptions will be made regarding emergency or sudden illness. If it is emergency or sudden illness please let us know at least **2 hours** prior to your scheduled session time or we will mark you as unexcused.
- 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.

I have read this policy and understand that I am responsible for any necessary payment and my child's attendance.

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.

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