SHELTERED RISKS INC. /Kamp Kessa
758 Beechridge Road
Frankfort, KY 40601

Participant Information Form

Name ______________________________ Social Security number: ________________

Home Phone ____________________ Cell Phone:- ____________________

Home Address ____

City ____________ State ________ Zip ________ Email Address ________________

DOB: _____ Age: ________ Height: ________ Weight: ________ Gender: ________ Race: ____________

Parent/Legal Guardian Name: ____

Address (if different from above:: ______________________________ Phone: ____________

School Name: ______________ Address: ____________________ Phone: ____________

Referral Source: ____________________ Email: ____________ Phone: ____________

How did you learn about Sheltered Risks Inc., : /Kamp Kessa? ______________________________

GOALS (i.e. *Why are you applying for participation? What would you like to accomplish?*) ____________________
____
____

In Case of Emergency:

Contact Name: ____________________ Home Phone: ____________ Cell Phone: ________________

Work Phone: ________________ Pager: ______________ Email Address: ____________________

Address: ________________________________ City, State: ____________ Zip: __________

Primary Care Physician: ______________________ City, State: ____________ Phone: ____________

Preferred Hospital: ______________________ City, State: ____________ Phone: ____________

In case of emergency, I give permission to SHELTERED RISKS INC./Kamp Kessa to secure medical treatment including x-ray, surgery, hospitalization and medications.

Date: ______________ Signature: ____

(Parent/Legal Guardian)

"No person in the United States shall, on the grounds of race, color, or national origin, be excluded from participation, be denied the benefits of, or be subject to discrimination under any program or activity receiving federal financial assistance."

Photo Release:

I □ DO □ DO NOT consent to and authorize the use and reproduction by SHELTERED RISKS INC./Kamp Kessa 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.

Date: ______________ Signature: ____

(Parent/Legal Guardian)

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Participant's Authorization for Emergency Medical Treatment Form

Participant's Name: ________________________________ Phone: __________________
Address: ________________________ City: ______________ State: _______ Zip: ________
Parent/Guardian Name:________________________________Phone: __________________
In the event of emergency, please contact:
Name:____________________________Relationship:____________Home Phone:__________________
Cell Phone:________________________Work Phone:__________________Pager:______________________
Address:__________________________________City, State:____________________Zip:__________
In the event the person named above cannot be reached, please contact:
Name:____________________________Phone:______________Relationship:____________________
Name:____________________________Phone:______________Relationship:____________________
Primary Care Physician:__________________________City, State:______________Phone:______________
Preferred Hospital:______________________________City, State:______________Phone:______________
Health Insurance Company:_______________________Policy ID #:______________Policy Group #:__________

Consent Plan
In the event emergency medical aid/treatment is required due to illness or injury during the process of receiving services, or while participating in activities or events sponsored by the agency, I authorize SHELTERED RISKS INC./Kamp Kessa to secure and retain medical treatment and transportation if needed. ***This authorization includes x-ray, surgery, hospitalization, medication and any treatment*** **d*eemed "life saving" by the physician. This provision will only be invoked if the person*(s) named above cannot *be reached.***

Please specify any allergies, conditions, or other information you feel important in the event emergency aid/treatment were necessary: ____
____
____

Date: ______________ Consent Signature: ____
Date: ______________Witness Signature: ____

Non-Consent Plan
I do not give my consent for emergency medical aid/treatment in the case of illness or injury during the process of receiving services, or while participating in activities or events sponsored by the agency. In the event emergency treatment/aid is required, I wish the following to take place:
____
____
____
Date: ______________ Non-Consent Signature: ____________________________________
Date: ______________ Witness Signature: ____
A COPY OF THE COMPLETED MEDICAL/HEALTH HISTORY SHOULD BE ATTACHED TO THIS FORM.

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Participant's Health History

Participant Name: ____**DOB:**_______________________

Diagnosis:_________________________________**Date of Onset:**______________________________

Past/Prospective Surgeries:____

Medications ***(include prescriptions, over-the counter, name, dose and frequency)*****:**_________________________
____
____
____

Date of Last Tetanus Shot: ____

Psycho/Social Function (***i.e. work/school including grade completed, leisure interests, relationships-family structure, support systems, companion animals, fears/concerns, etc):*** ______________________________________
____
____**Special Precautions/Needs:**_____
____
____
____

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

___Vision	**___Hearing**	**___Sensation**
___Communication	**___Heart**	**___Breathing**
___Digestion	**___Elimination**	**___Circulation**
___Emotional/Mental Health	**___Behavioral**	**___Pain**
___Bone/Joint	**___Muscular**	**___Thinking/Cognition**
___Allergies	**___Immunity**	**___Pulmonary**
___Neurological	**___Balance**	**___Pain**
___Other(s)		

Date:_________________**Parent/Legal Guardian Signature:**__________________________________

Physician's Statement

To my knowledge, there is no reason why this person cannot participate in supervised equestrian activities. However, I understand that SHELTERED RISKS INC./Kamp Kessa will weigh the medical information against the existing precautions and contraindications. I concur with a review of this person's abilities/limitations by a licensed/credentialed health professional (e.g. PT, OT, SLP, Psychologist, etc) in the implementation of an effective equine activity program.

Comments:____
____
____

Name/Title ____**MD DO NP PA Other**

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Participant's Profile

Participant's Name:________________________________Nickname:____________Age:__________
DOB:_________Gender:_______ Height:_______ Weight:_______Grade in School:______________
Parent/Legal Guardian:____
Address:____
Home Phone:________________Work Phone:________________Cell Phone: __________________
Email:____

Psychiatric Treatment History

Where? When? Diagnosis?:____
____
____

Current Therapy?:____
____
____

Outpatient Therapy?:___`____
____
____

Inpatient Therapy?: ____
____
____

Physician Name:____Phone:______________________
Psychiatrist Name:_______________________________________Phone:______________________
Therapist Name:____Phone:______________________

Therapeutic and Safety Issues

Check and describe all past and current issues (please provide details):

___inattention	___hyperactivity	___lack of concentration
___learning disabilities	___developmentally delayed	___mentally challenged
___boundary issues	___social skills problems	___problems with peers
___separation anxiety	___anxiety	___phobias
___aggressive	___assaultive	___manipulative
___sensory impairment	___sensitivity, preferences	___tics or stereotypic behavior
___psychosomatic symptoms	___medical issues	___self-injurious behavior
___suicidal ideation	___history of runaway	___issues of parental support
___issues of family support	___sexual abuse/acting out	___physical/emotional abuse
___hallucinations	___delusions	___dissociation
___substance abuse problems	___legal problems	___school problems
___history of animal abuse	___seizure disorder	___allergies
___history of vandalism or fire starting		___weight control disorder
___unpredictable or dangerous behavior		___thought control disorder
___other(s)		

Experience with horses

DETAILS: ____
____
____
____

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Participant's Consent for Treatment, Release of Liability, and Confidentiality Form

No child can be accepted until all forms have been completed by the parent/guardian. If the patient is of legal age and mentally competent, he/she may complete the forms without parent/guardian signatures.

As a participant at SHELTERED RISKS INC./Kamp Kessa, I acknowledge the risks and potential for risks of a horseback riding/wilderness program. However, I feel that the possible benefits are greater than the risk assumed. I understand that I am required to wear protective gear addressed in each activity guideline (e.g. helmet must be worn while riding horse).

Although every effort will be made to avoid accident or injury, NO LIABILITY can be accepted by any of the organizations including SHELTERED RISKS INC./Kamp Kessa, its officers, trustees, agents, employees, and each and every one of its members and associates, the property owners upon whose land the hippotherapy sessions are conducted.

I request to and consent to treatment that may include hippotherapy, and I have discussed this with my child. I understand that no liability can be accepted by any of the organizations concerned with this therapy including SHELTERED RISKS INC./Kamp Kessa.

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 SHELTERED RISKS INC./Kamp Kessa, its board of directors, instructors, therapists, counselors, volunteers or employees for any and all injuries and/or losses I may sustain while participating in SHELTERED RISKS INC./Kamp Kessa.

Date:______________ Parent/Guardian Signature:_______________________________

Date:______________SHELTERED RISKS INC./Kamp Kessa Signature:___________________
____

Client Confidentiality

It is the policy of . to ensure that all information concerning clients will be kept confidential. Client records will be kept in a file in a locked office. Only employees that work with given clients or staff that prepare reports will have access to those records. The only time confidential client information will be released is by the informed consent of the client or his/her legal representative or by order of the court.
SHELTERED RISKS INC. recognizes the need for authorized federal, state, local or SHELTERED RISKS INC. staff to have access to the client files for the purpose of program monitoring (ie. HMIS) Should client information need to be used for reports or examples, all client identifying information such as name, address and social security

numbers shall be removed or blacked out before releasing. Staff are required to sign an Employee Confidentiality/Security Agreement that spells out specific information and records that must be kept confidential.

Directions:
Take exit 43 (395Waddy/Peytona) off of highway 64 (between Shelbyville and Frankfort Kentucky) Take 395 North for around 4 miles. Take a Right on 1779. Go 3.2 miles. You will see a , Kamp Kessa sign as the road turns sharply to the left. Go right on the access road and take the first drive to the left. Go down to the pole barn to check in.
See you at Kamp Kessa Check in Time is between 1 and 3 pm on Sunday!

Do not bring any electronic equipment, cell phones, gameboys, radios, headphones, etc. This is a wilderness setting. ***Thank you.***

. (SHELTERED RISKS INC.) / Kamp Kessa
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Client Rights Policy

All clients of . are guaranteed the following rights:

The right to be treated with consideration and respect concerning privacy, personal dignity and independence.

The right to be informed of one's own condition, of suggested or current services, and of different choices.

The right to agree to, or refuse, any services and to have the consequences of that choice explained.

The right to an up-to-date, written treatment/service plan that addresses family needs and available services.

The right to participate in the creation and review of the treatment/service plan.

The right to confidentiality concerning all personally identifying information within the guidelines spelled out by Kentucky and Federal law.

The right to be informed in advance of the reason(s) if services are discontinued, and to be involved in planning for the consequences of that event.

The right to receive an explanation if services are denied.

The right not to be denied service on the basis of religion, race, color, creed, sex, national origin, age, sexual orientation or disability.

The right to be fully informed of all rights.

The right to exercise any of these rights without negative consequences of any kind.

Client signature: ___________________________________

Date: ____________________

Witness signature: ________________________________

Date: ____________________

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DUTY TO WARN

Confidentiality and privileged communication remain rights of all clients of .. However some courts have held that if an individual intend to take harmful, dangerous, or criminal action against another human being, or against themselves, it is the counselor's duty to warn appropriate individuals of such intentions. Those warned may include a variety of persons such as:

1.The person or family of the person who is likely to suffer the results of harmful behavior;

2. The family of the client who intends to harm themselves or someone else;

3.Associates or friends of those threatened or making threats;

4.Appropriate social service agencies;

5.Law enforcement officials

Before informing anyone who should be warned, the counselor will take all possible steps to first share that intention with the client. Every effort will be made to resolve the issue with the client so as to prevent any such breach of confidentiality.

Date (SHELTERED RISKS INC. Staff)

I have read the above and understand the staff's social responsibility to make such a decision where necessary.

Client or Legal Guardian: ______________________________

Date:

. (SHELTERED RISKS INC.) / Kamp Kessa
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I, ____ give permission for my child

____ to participate in the following activities at Kamp Kessa under the supervision of qualified staff:

Wilderness activities including initiative games and low ropes
Horse activities and horse riding (helmets will be worn)
Fishing and water studies
Camping in the wilderness (by appointment only)
Backpacking/trailpacking
Hay ride on a wagon pulled by a tractor
Transport to and from activities in a motor driven vehicle
Such activities as caving, canoeing provided by vendors.
Dispense medication as prescribed by physician or as indicated by condition

SHELTERED RISKS INC.'S Kamp Kessa
Consent and Release of Liability

In consideration or the furtherance of your purposes, objectives, and work and in consideration of your permitting me, my child, ward, or heir to participate in a Kamp Kessa, or other related event, I, the undersigned, and if under the age of 18, my parent or guardian, intending to be legally bound, hereby waive and release any and all right and claims for damages, whether based upon negligence or any other theory of law, which I, my child, ward or heir, and our parents, guardians, heirs, executors, representatives, administrators, successors and assigns, for any and all injuries or damages which I, my child, ward or heir may suffer while taking part in the event or as a result thereof. I verify that I, my child, ward or heir will participate in this event as an entrant, and that the entrant is physically fit and able to participate in and complete the event.
I give my permission for Kamp Kessa staff to escort and grant permission to treat my child at the nearest emergency room should an accident occur. I understand that I will be contacted if said occasion occurs.

I understand that I am the responsible party if any accident occurs, including all medical expenses should they occur.

Parent or guardian signature: _____________________________________Date:___________

Emergency Contact number: _________________________

Day:________________________

Evening:______________________