Mane Stream
PO Box 305 • Oldwick, New Jersey • 08858
Tel: (908) 439-9636 • Fax: (908) 439-2338
Web: www.manestreamnj.org

February 2023

Dear Camper/Parent,

Thank you for your interest in Mane Stream's Summer Camp. Mane Stream's Summer Camp is an inclusive day camp open to any child four years of age and older. Enclosed you will find information about camp, eligibility guidelines and all the required forms (including an immunization record from the doctor) to be returned to the office prior to the beginning of Summer Camp.

Any child attending camp must have independent bathroom skills and be able to care for and feed him/herself. Please note: Mane Stream is not able to administer medications.

Campers that have not previously attended Summer Camp at Mane Stream must attend a screening prior to participating to ensure that the camp experience will be an appropriate activity for the camper. This 30-minute screening will consist of a tour of the facility, a brief ride on a horse or pony and an informal meeting with a Mane Stream instructor. This meeting will give the Mane Stream a chance to get to know the camper and recommend the appropriate week for the camper to attend. There is no fee for the screening. All paperwork must be completed before the screening can be scheduled. Once the completed paperwork is received in the office, you will be contacted to schedule the screening.

Camp enrollment is limited to six campers per week to ensure a safe and fun environment. Camp is supervised by the Camp Director, PATH Intl Certified Riding Instructors, and Camp Counselors. The Camp Director, the Camp Health Director and PATH Instructors are CPR and First Aid Certified. In addition, specially trained Mane Stream volunteers assist with activities throughout the day.

Campers are welcome to attend as many weeks as they want. Be sure to send in your paperwork as soon as possible- the weeks fill quickly. All registered campers will receive a confirmation packet prior to attending, along with any additional required paperwork that is needed.

For more information, please contact:
Kathy Dermody, Camp Director
kathy@manestreamnj.org.

You can also call the office at 908-439-9636.

Mane Stream

CAMPER DISCIPLINE POLICY

Mane Stream staff and volunteers must understand that while it is important to maintain order with campers, camp is a recreational experience that is supposed to be fun. However, it is imperative that all campers comply with instructions relating to safety issues. If a camper repeatedly ignores or defies an instruction from a camp counselor and in doing so is jeopardizing his/her safety or that of others and/or causing serious disruption to the program the following steps will be taken:

1. The camper will be placed in "time-out" for an amount of time that is equal in minutes to the child's age in years (e.g. A six-year-old child would be in time-out for six minutes).
2. Any child in "time-out" would remain in the same area as the camp activity taking place but would not be permitted to participate for the length of the time-out.
3. Any child in "time-out" would be directly supervised by a camp counselor during the time-out.

If a child is place in "time-out" but refuses to comply, his/her parent will be called and the child sent home for that day. If a child is sent home for disciplinary problems for three consecutive days the child will not be permitted to complete the camp session. No child will be verbally or physically abused or deprived of food.

Health Surveillance Procedures

The Camp Health Director will institute the following procedures for all campers and for the duration of each camp session:

1. Parents will be given Camp "Health & Safety Rules" information which will include a list of camp rules regarding health and safety to be discussed with their child, and a "Health Alert" form.

2. Parents will be asked to fill out a "Health Alert" form with any concerns or observations that they may have regarding a child's appetite, attitude, etc., but are not related to an obvious health problem, for each day as necessary while the child is attending camp. In the case of an obvious health problem the child should remain at home.

3. The Camp Health Director and/or camp staff members will visually check each camper upon arrival at camp for any bruises, rashes or illnesses as well as any changes or problems in appearance, attitude and appetite which may indicate a health problem. Such observations will be recorded and reported to the camp director who will decide upon the action required. Serious concerns will be reported to the child's parent immediately and arrangements will made for the child to be sent home.

Mane Stream
HEALTH AND SAFETY RULES

To All Parents: The following is a list of rules that must be observed in order for your to child to participate in camp. Please discuss these rules with your child and make sure that he/she understands them. Please also review the Camper Discipline Policy with your child. These rules are designed to ensure that your child has a happy and safe camp experience. However, you should be aware that all equestrian activities involve a significant inherent risk due to the size, nature and behavior of horses. Please refer to the NJ warning (NJ P.L. 1997, c. 287, C:5:15-1 et seq).

1. The instructions of camp staff must be obeyed at all times.
2. Campers are not permitted in areas that are "off-limits" without supervision by camp staff. This includes any area on the front side (facing road) and driveway side of the barn, all pastures (fenced fields), water troughs, hayloft, storage area and any area not part of Mane Stream property (farm fields).
3. Running in the barn or near the horses is dangerous and is not permitted.
4. Walking directly behind horses is not permitted.
5. No camper may open or enter a stall when a horse is in it.
6. No camper may reach their hand/arm into a stall when a horse is in the stall.
7. Offering treats to horses is prohibited without the approval of and under the direct supervision of a camp staff person.
8. Riding helmets must be worn at all times during lessons.
9. Helmets must be ASTM-SEI approved.
10. Proper footwear must be worn for riding (heels and flat soles). Any camper without proper footwear will not participate in riding lessons.
11. For the consideration of all campers (including your child) any child who is ill should be kept at home.
12. Mane Stream is not responsible for any personal belongings (toys, games, etc.) brought to or left at camp.
13. Any camper who has not returned the required paperwork (camp registration & medical forms) to Mane Stream by the start of the camp session that he/she is enrolled in will not be permitted to participate until the completed form is presented to Mane Stream.

I have read and understand the Mane Stream Health and Safety information and have reviewed Mane Stream policies and procedures with my child.

_____ _____

Signature of Parent/Guardian Date

_____

Camper's Name

ALLERGY NOTICE

Campers may make horse treats with the following food items.
Please make the appropriate choice:

___ *I give permission for my child to partake in activities that involve **any** of the following foods*

___ *I **do not** give permission for my child to partake in activities that involve any of the following foods*

___ I give permission for my child to partake in activities involving **only** the foods that I have circled

To make horse treats:	peppermints	oats (horse feed)
	molasses	grain (horse feed)
	apples	carrots

*Note:

_____ _____
Signature of Parent/Guardian Date

_____
Printed Name

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PARTICIPANT

Today's Date: _____

PARTICIPANT INFORMATION

Participant's name: _____ Preferred name: _____

Preferred Gender: ❑ M ❑ F ❑ Gender nonconforming ❑ Decline to answer

❑ Additional gender category (please specify): _____

Pronouns: _____ DOB: _____

Parent name: _____ Parent name: _____

Legal Guardian(s) (if other than parent): _____

Street: _____ Town: _____

State: _____ Zip: _____ County of Residence: _____

CONTACT INFORMATION

Contact Person	*Phone*	*Contact person*	*Phone*
Home: _____	_____	Home: _____	_____
Cell: _____	_____	Cell: _____	_____
Work: _____	_____	Work: _____	_____
Email: _____ ❑		Email: _____ ❑	

Mane Stream prefers to use email for all correspondence. Which email should we use for all communication?

Primary contact person & phone numbers for cancellations, etc.:

1) Contact: _____ Phone: _____ ❑ okay to text

2) Contact: _____ Phone: _____ ❑ okay to text

AUDIO-VISUAL RELEASE

I hereby: *(choose one)* ☐ **consent** to and authorize *or* ☐ **do not consent** to or authorize the use and reproduction of any and all photographs and any other audiovisual materials taken of me/my child by Mane Stream for promotional printed material, educational activities, website, Facebook and exhibitions, by PATH Intl., AHA, Inc., EAGALA or for any other use for benefit of the Mane Stream program.

Participant/Legal Guardian Signature: _____ Date: _____

Mane Stream
MEDICAL RELEASE

Participant:_____ **Date of Birth:** _____
(Print Name)

Authorization:
In case of emergency I hereby authorize myself, my child or ward to be treated by Certified Emergency Personnel. (i.e. EMT, First Responder, E.R., Physician)

Family Physician: _____ Phone: _____
Address: _____
Hospital Preference: _____

In case of emergency contact:

_____
Name Phone Number Relationship to Client

_____
Name Phone Number Relationship to Client

Please list any allergies/medical problems, including those requiring maintenance medications (i.e. Diabetic, Asthma, Seizure Disorder).

_____

_____

_____

Date of last seizure:_____

The purpose of the above listed information is to ensure that medical personnel have details of any medical problem which may interfere with or alter treatment.

Medical Diagnosis	**Medication**	**Dosage**	**Frequency of Dosage**

Date of last Tetanus Toxoid Booster: _____

_____ _____
Participant Signature **Date**

Mr./Mrs./Ms. _____ _____
Authorized Parent/Guardian Signature **Date**

Mane Stream

ACCIDENT WAIVER AND RELEASE

In consideration of being permitted to participate in the equine related services and activities at Mane Stream, Inc., ("Mane Stream") located in Oldwick, New Jersey (collectively referred to as the "Activity")
I,_____, on behalf of myself OR on behalf of _____, hereby:

1. Acknowledge and agree that I am voluntarily participating in the event of my own free will.

2. Fully understand that the Activity involves risks and dangers, including but not limited to property damage, bodily injury, disability and possibly death. I understand that these risks may be caused by the nature of the Activity itself, the use or misuse of equipment, my own action or inaction, the action or inaction of others participating in the Activity or the action or inaction of the Releasees (named below).

3. Understand and acknowledge that I am voluntarily assuming all risks associated with or arising out of participating in this Activity, whether foreseeable or unforeseeable, including but not limited to those risks described in paragraph 2 above.

4. Acknowledge, agree and represent that I understand the nature of the Activity and that I am qualified and physically able to participate in such Activity. I further agree and warrant that if at any time I believe conditions to be unsafe, I will immediately discontinue further participation in the Activity.

5. Agree to release Mane Stream and any of its owners, administrators, directors, agents, officers, members, volunteers, employees, successors and assigns (each, a "Releasee" and collectively, the "Releasees") from any and all claims past, present and future, known or unknown, that I, my heirs, executors, administrators or any other person on my behalf may have and that arise in connection with my participation in the Activity.

6. Agree to indemnify Releasees for, from and against each and every demand, claim, loss (which shall include any diminution in value), liability, judgment, damage, cost and expense (including, without limitation, interest, penalties, costs of preparation and investigation, and the reasonable fees, disbursements and expenses of attorneys, accountants and other professional advisors) (collectively, "Losses") suffered by any and all of the Releasees as a result of my participation in the Activity, including, but not limited to, Losses sustained as a result of a third-party claim against the Releasees arising from participation in the Activity, Losses sustained by Releasees in seeking medical treatment for me in connection with my participation in the Activity, and/or Losses resulting from Releasees' efforts to enforce this Waiver and Release.

7. Acknowledge and understand that Releasees are not responsible for the actions or inactions of any third parties hosting or conducting any event or activities related to the Activity.

8. Understand and acknowledge that this Waiver and Release is governed in all respects by the laws of the State of New Jersey, irrespective of conflicts of laws rules.

9. Acknowledge that I, or the person I am signing on behalf of is receiving valuable consideration through participation in the Activity, the receipt and sufficiency is hereby acknowledged.

I HAVE READ THIS WAIVER AND RELEASE, FULLY UNDERSTAND ITS TERMS, UNDERSTAND THAT I HAVE GIVEN UP SUBSTANTIAL RIGHTS BY SIGNING IT AND HAVE SIGNED IT FREELY AND WITHOUT INDUCEMENT OR ASSURANCE OF ANY NATURE AND INTEND IT TO BE A COMPLETE AND UNCONDITIONAL RELEASE OF ALL LIABILITY TO THE GREATEST EXTENT ALLOWED BY LAW AND AGREE THAT IF ANY PORTION OF THIS AGREEMENT IS HELD TO BE INVAVLID, THE BALANCE, NOTWITHSTANDING, SHALL CONTINUE IN FULL FORCE AND EFFECT.

Full Name (print): _____

Signature: _____Date: _____

OVER PLEASE

Mane Stream

ACCIDENT WAIVER AND RELEASE

PARENT / GUARDIAN WAIVER FOR MINORS OR WARDS

The undersigned parent and/or guardian does hereby represent that he/she is, in fact, acting in such capacity, has consented to his/her child or ward's participation in the Activity, and has agreed individually and on behalf of the child or ward to the terms of the accident waiver and release of liability set forth above. The undersigned parent or guardian further agrees to save and hold harmless and indemnify each and all of the parties referred to above from all liability, loss, cost, claim, or damage whatsoever which may be imposed upon said parties because of any defect in or lack of such capacity to so act and release said parties on behalf of the participant and the parents/guardian.

Full Name: _____

Signature: _____ Date: _____

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PARTICIPANT INFORMATION

Identifying Information

Name: _____ Age: _____ Today's Date: _____

Participant's grade in school or educational level: _____

School or employer: _____

Personality Profile

Please describe the participant's personality:

_____

_____

_____

_____

List the participant's favorite activities and/or preferences?

_____

_____

_____

_____

List any fears or dislikes the participant may have?

_____

_____

_____

_____

Communication Preference

___ *verbally* ____ *assistive device* ____ *sign language*

____ *picture icons* ____ *gestures* ____ *sounds*

Assistive Devices

Please list any devices that the participant may use at home or school

- ☐ Wheelchair: Power_____ Manual _____
- ☐ Stroller
- ☐ Walker
- ☐ Crutches/braces- _____
- ☐ Stander
- ☐ Gait trainer
- ☐ Orthotics- _____
- ☐ Splints- _____
- ☐ Prosthetics- _____
- ☐ Cervical collar, TLSO, abdominal binder, other trunk support
- ☐ Other assistive devices- _____

Participant/Family Goals

_____

_____

_____

_____

_____

_____

_____

Mane Stream is a PATH Premier Accredited Center striving to provide the highest quality adaptive riding instruction and outpatient therapy for our participants. Thank you for taking the time to help us provide the best possible services.

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Dear Health Care Provider:

Your patient is interested in participating at the Mane Stream. In order to safely provide services, our center requests you to complete the attached "Annual Medical History and Physician's Statement."

The Professional Association of Therapeutic Horsemanship International and the American Hippotherapy Association, Inc. have written guidelines pertaining to precautions and contraindications for individuals participating in equine related activities. Therefore, when completing the "Annual Medical History and Physicians Statement," please note if these conditions are present and to what degree. The following is a list of suggested precautions and contraindications:

Orthopedic:
Atlantoaxial Instability
Coxa Arthrosis
Cranial Deficits
Heterotopic Ossification/Myositis
Ossoficans
Joint Subluxation/dislocation
Osteoporosis
Pathologic Fractures
Spinal Fusion/Fixation
Scoliosis
Spinal Instability/Abnormalities

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

Other:
Age- under 2 years
Indwelling Catheters
Medications – i.e. photosensitivity
Poor endurance
Skin Breakdown

Medical/Psychological:
Allergies
Animal Abuse
Physical/Sexual/Emotional Abuse
Blood Pressure Control
Dangerous to self or others
Exacerbations of medical conditions
Fire Settings
Heart Conditions
Hemophilia
Medical Instability
Migraines
PVD
Respiratory Compromise
Recent Surgeries
Substance Abuse
Thought control disorders
Weight control disorder

Precautions and Contraindications

The primary focus of any facility offering equine related services is to provide a safe and productive experience for all participants. The question that must be asked is "Will the benefit outweigh the risk?" The general rule is "do no harm."

A precaution is defined as a measure taken beforehand against possible danger, failure, etc. Participants with precautions may require modifications to their program, additional equipment, and always require re-evaluations at regular intervals to assure the effectiveness of participation.

A contraindication is a condition or symptom that makes equine related services inappropriate. Few contraindications are clear-cut. A contraindication may be permanent; meaning some activities may never be appropriate for certain participants due to safety or health concerns. A contraindication may also be temporary until the participant's health or condition improves. A participant may also begin with equine related services as

part of their program, but may find it no longer safe to include equine movement with the progression of his or her disability.

The following must be considered when deciding to include equines:

- Most equine related services inherently involve movement. If the movement will cause a decrease in the participant's function, an increase in pain, or generally aggravate the medical condition it may not be the intervention of choice.
- The essence of equine related services is the human-animal connection. If this interaction is detrimental to the participant or the equine, services may be contraindicated.
- Equine related services always presents the potential for a fall. Such a fall may cause a greater functional impairment than the participant originally had. The possibility of a fall should be given careful consideration and may lead to the informed decision.
- Working around equines (i.e. grooming, leading, etc.) involves risk. Even the well-trained equine is subject to its instinctive fight or flight responses. Horses are large, move quickly, and can be dangerous to the participant who is unable to respond appropriately.

Atlantoaxial Instability in Down Syndrome as Related to Equine Related Services

Potential participants and parents of potential participants should be aware of the inherent risks involved with equine related services for individuals diagnosed with Down syndrome and/or atlantoaxial instability. Mane Stream is guided by the recommendations of PATH International, AHA Inc., and Special Olympics, all recognized experts in the area of activities for people with disabilities.

There is evidence that 10-20% of individuals with Down syndrome suffer from Atlantoaxial Instability. Atlantoaxial Instability can be defined as instability, subluxation or dislocation of the joint between the first and second cervical vertebrae (atlantoaxial joint). Instability of the joint is generally due to poor muscle tone and ligament laxity that is common with Down syndrome.

A lax joint may begin to put pressure on the spinal cord resulting in the following **neurologic symptoms**:

- Change of head control-head tilt, torticollis/wry neck, stiff neck
- Change of gait- progressive clumsiness, toe walking or scissoring, falling, posturing
- Change of hand control- progressive weakness, fisting, change of dominant hand, increasing tremor
- Change of bladder function
- Change of bowel function
- Increase in muscle tone
- Fatigue

Neurologic signs always supersede radiographs and can be considered a contraindication.
Atlantoaxial Instability exposes individuals with Down syndrome to the possibility of injury if they participate in any activity the hyper-extends, radically flexes, or creates direct pressure on the neck or upper spine. This condition can occur spontaneously or be induced by injury that results from excessive anterior movement of the upper spine.

Although every precaution is taken at Mane Stream to make services as safe and as risk free as possible, there is always risk involved when working around or sitting on a horse. Even the quietest of horses are by nature unpredictable, thereby increasing the possibility of an injury. A fall from a horse, a sudden movement of the horse, or even the horse's normal stride/movement can create hyper-extension or hyper-flexion of the neck and upper spine.

PATH International requires that all potential participants with Down syndrome have a medical examination by a licensed physician including a complete neurological exam that shows no evidence of AAI or neurologic symptoms. This information must be noted on the Annual Medical History and Physicians Statement. Thereafter an annual examination from a physician or qualified medical professional stating that the participant's physical exam reveals no signs of AAI or decrease in neurologic function is required for continued participation in any equine related services at Mane Stream.

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ANNUAL MEDICAL HISTORY and PHYSICIAN'S STATEMENT

By providing this form to my or the participant's physician, I provide my consent for their disclosure of the information about the named participant required in this form to Mane Stream. Information is kept confidential.

Participant's Information

Participant's name: _____ Today's Date: _____
Address: _____
DOB: _____ Gender: M ____ F ____

Height: _____ **Weight**: _____ ***Physician's initials are required here*** _____
It is crucial that this information be truthful and accurate. To provide inaccurate information may jeopardize the safety of the participant and others.

Medical Summary

Primary diagnosis: _____ Cause if known:_____
Other diagnoses: _____
If Down Syndrome/AAI- result of yearly neurological exam/test for AAI: ❑Negative ❑Positive
Results/date of exam/test:_____
Recent surgical procedures or hospitalization: _____
Brief current medical condition: _____
Date of last tetanus: _____

Current Medications

Name: _____ Dose: _____ For treatment of: _____
Name: _____ Dose: _____ For treatment of: _____
Name: _____ Dose: _____ For treatment of: _____

Abilities

Assistive Aids (*please check all that currently apply to the client, or note history in space provided*):
_____ Orthotics/Splints/Prosthetics (*specify type*): _____
_____ Cervical collar/Abdominal binder/Other trunk supports (*specify type*): _____
_____ Wheelchair/Walker/Crutches (*specify type*):_____
_____ Other assistive aids: _____

Physical Skills (*please rate the following skills using the scale provided*):

(**0**) *Not able to perform skill that at this time* (**1**) *Beginning Skill requires moderate assistance from others* (**2**) *Moderate Ability requires minimal assistance from others* (**3**) *Mastered is performed independently*

_____ Head and neck control _____
_____ Unsupported sitting balance _____
_____ Unsupported standing balance _____
_____ Unsupported walking _____
_____ Upper extremity (arm) strength / movement _____
_____ Lower extremity (leg) strength / movement _____
_____ Fine motor (hand/finger) strength / movement _____
_____ Gross motor (whole body) coordination _____

ANNUAL MEDICAL HISTORY and PHYSICIAN'S STATEMENT

Cognitive Skills (*please rate the following skills using the scale provided*):

(**0**) *Not able to perform skill at this time* (**1**) *Beginning Skill requires moderate assistance from others* (**2**) *Moderate Ability requires minimal assistance from others* (**3**) *Mastered is performed independently*

_____ Alertness/Attention _____
_____ Ability to follow 1-step commands _____
_____ Ability to follow multiple-step commands _____
_____ Activity level / endurance _____
_____ Visual ability _____
_____ Expressive Language_____
_____ Language Comprehension _____
_____ Socialization skills _____

Precautions/Contraindications (*Please check all that currently apply to your patient and degree of involvement, or note history in space provided. Please note that the following conditions may be a contraindication to participation*):

_____ Allergies (*specify type*)_____
_____ Arthritis (*rheumatoid or osteo*) _____
_____ Asthma _____
_____ Atlanto-Axial Instability- positive X-ray or positive neurological exam_____
_____ Behaviors _____
_____ Blood clots, deep vein thrombosis, peripheral vascular disease _____
_____ Body temperature regulation problems _____
_____ Bone abnormalities (*osteoporosis, pathologic fractures*) _____
_____ Brain injury _____
_____ Communicable Diseases _____
_____ Contractures/limited ROM (*location*) _____
_____ Gastro-intestinal or naso-gastric, or tracheal tube _____
_____ Heart condition/abnormality _____
_____ Hypertension _____
_____ Joint/tendon laxity, subluxation, dislocation _____
_____ In-dwelling catheter _____
_____ Shunt _____
_____ Psychiatric condition (*type*) _____
_____ Respiratory complications (*type*) _____
_____ Seizures (*list type, frequency and duration*) _____
Date of last seizure: _____
_____ Skin integrity issues, skin breakdown, skin/decubitus ulcers _____
_____ Chiari II malformation, tethered cord (*include release date*) _____
_____ Scoliosis _____
Location & degree of curve: _____
_____ Spinal fusion or internal fixators (*specify area, type, vertebrae involved*): _____
_____ Other (*please specify*) _____

Physician's Statement

In my capacity as medical advisor, I consent to the participation of _____ *(Patient's full name)* in the horseback riding program and/or therapy services at Mane Stream. I certify that all of the information that I have given is accurate and represents a complete medical history.

Physician's name: _____ **Date:** _____
Address or stamp:

Physician's Signature: _____