Great Strides
LONG ISLAND
HORSES FOR BODY, MIND AND SOUL

For Office Use Only
Program_____
Instructor_____

RELEASE BY AN INDIVIDUAL FOR PARTICIPATION IN EQUESTRIAN ACTIVITIES

PLEASE READ THIS CAREFULLY AND BE AWARE THAT IN PARTICIPATING IN HORSE-RELATED ACTIVITIES AT THIS FACILITY, YOU WILL BE WAIVING AND LIMITING ALL CLAIMS FOR INJURIES ARISING OUT OF THESE ACTIVITIES THAT YOU OR THE OTHER OR THE OTHER NAMED PARTICIPANTS MIGHT SUSTAIN.

This Release executed on _____, 20 ____

By Participant over 18 years old _____, OR
Print Name
By (Parent and natural guardian) _____, OR
Print Name
By Court Appointed Legal Guardian _____,
Print Name
Residing at _____(Please
Full Address, including zip code
include zip code), State of New York.
Phone Number _____ on behalf of myself as "Releasor" and Participant under 18 years of age or otherwise lacking capacity (Name of Participant) _____ Referred to as "Participant" for the period of one year commencing with the execution of this agreement. This agreement runs to the benefit of Great Strides Long Island, Inc, ("Program"), and the individuals assisting in any riding activities performed by the Participant.

The terms "I", "Me" and "My" also refer to parents or guardians as well as participants in the program. In participating in these programs and utilizing these facilities, you are agreeing as follows:

WARNING: UNDER NEW YORK LAW, AN EQUINE PROFESSIONAL OR EQUINE ACTIVITYSPONSOR IS NOT LIABLE FOR AN INJURY TO OR THE DEATH OF A PARTICIPANT IN EQUINE ACTIVITIES RESULTING FROM THE INHERENT RISKS OF EQUINE ACTIVITIES, PURSUANT TO SECTION 18-404 OF THE GENERAL OBLIGATIONS LAW.

As a user of these facilities, I recognize and acknowledge that there are certain risks of physical injury and I agree to assume the full risk of any injuries, damages or loss of which I may sustain as a result of participating in any manner in any and all activities connected or associated with such a program and in such a facility. I further recognize and acknowledge that interaction with horses involves substantial risks of injury.

I agree to waive and relinquish and all claims I may have as a result of participating in the program and using the facility and all independent contractors, volunteers, officers, agents, servants and employees of the governmental bodies and independent contractors and any and all other injuries that I might sustain while participating in facility activities. (The parties described in the preceding sentence are referred to as the released parties in the remainder of this agreement.)

I do hereby fully release and discharge the Facility and the other released parties from any and all claims for injuries, damage or loss which I may have or which may occur to me on account of my use of this facility.

I understand the nature of the facility which I will be using and have read and fully understand the Waiver Release and Hold Harmless Agreement.

Releasor states and affirms that he or she is over the age of 18 years and is the parent or guardian of the Rider set forth above. Releasor further affirms that he or she has carefully read this release and understands the contents thereof and executes it freely and voluntarily.

Email:_____

_____ _____

(Print Name of Participant/Releasor) (Signature of Participant/Releasor)

_____ _____

(Print Name of Parent or Legal Guardian) (Signature of Parent or Legal Guardian)

_____ _____

(Facility Witness Print Name) (Today's Date)

Saddle Rock Ranch

A service of Family Residences and Essential Enterprises, Inc.

For Office Use Only

Program_____

Instructor_____

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Full Address, including zip code

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Email:_____

_____ _____

(Print Name of Participant/Releasor) (Signature of Participant/Releasor)

_____ _____

(Print Name of Parent or Legal Guardian) (Signature of Parent or Legal Guardian)

_____ _____

(Facility Witness Print Name) (Today's Date)

PHOTO RELEASE

I, _____

Hereby grant permission to Great Strides Long Island, Inc. to take pictures of me to be used in the organization's marketing materials (i.e. articles, newsletters, brochures, journals, advertisements, website etc.).

I agree to allow my name to be utilized in the publications of this photo. It is understood that said pictures or articles are intended to project a very positive image of the individuals who participate in programs and to benefit the cause of Great Strides Long Island.

_____
Signature

_____
Name

_____
Date

_____
Address

_____
Phone

Authorization for Emergency Medical Treatment Form

☐ Participant ☐ Staff ☐ Volunteer

Name:_____

DOB: _____ Phone: _____

Address:_____

Preferred Medical Facility: _____

Health Insurance Company: _____ Policy #: _____

Allergies to medications:

_____

Current medications:

_____

In the event of an emergency, contact:

Name: _____Relation: _____ Phone:_____

Name: _____Relation: _____ Phone:_____

Name: _____Relation: _____ Phone: _____

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 Saddle Rock Ranch to:
1. Secure and retain medical treatment and transportation if needed.
2. Release client records upon request to the authorized individual or agency involved in the medical emergency treatment.

Consent Plan

This authorization includes x-ray, surgery, hospitalization, medication and any treatment procedure deemed “life-saving” by the physician. This provision will only be invoked if the person(s) above is unable to be reached.

Date: _____ Consent Signature:_____

Non-Consent Plan

I do not give my consent for emergency medical treatment/aid in the case of illness or injury during the process of receiving services or while being on the property of the agency.

☐ Parent or legal guardian will remain on site at all times during equine assisted activities

☐ In the event emergency treatment/aid is required, I wish the following procedure to take place:

_____

_____

Date: _____ Non-Consent Signature: _____

Client, Parent or Legal Guardian

Form OMR 106 (MR)(12/05)

Request for Criminal History Record Check

NYS Office of Mental Retardation and Developmental Disabilities
Criminal Background Check Unit
PO Box 3005
Schenectady, NY 12303-0005
cbc.unit@omr.state.ny.us

This form is to be used only by voluntary agencies and DDSOs. The purpose of this form is to formally request a criminal history record check. For state employees, DDSO should use Form OMR 106S.

Instructions:

1. Complete all fields on the form. Please print legibly.
2. Authorized party must sign and date the form.
3. If Livescan prints are being taken, give completed form to applicant to bring to Livescan location.
4. If "ink and roll" is being used, mail the completed form along with fingerprint cards and Form OMR 107 to the CBC Unit at above address.

Agency/DDSO Name	Agency Corp ID

Applicant's Last Name	First Name	MI

Date of Birth	Social Security Number

Street Address or PO Box (applicant's)

City	State	Zip

Status (check one)	Position Type (check one)	Program Type
☐ E – Employee (non state)	☐ Support	(four digit code select from page 2)
☐ V – Volunteer	☐ Administrative	
☐ F – Family Care Provider	☐ Clinical	___ ___ ___ ___
☐ A – Adult household member	☐ Direct Care	
☐ R – Family Care Respite/substitute	☐ Not Applicable	
☐ H – Adult household member		
☐ N – Employees of vendors and contractors		

The applicant will have regular and substantial unsupervised or unrestricted physical contact with individuals receiving services and is a subject party concerning whom a criminal history record check is required by law. The results of the criminal history record check will be used solely for purposes authorized by law. Informed consent has been given by the applicant and is on file.

Please check if applicable:

☐ This is an expedited request (see CBC Policy 101.3 for expedited criteria).
☐ A request for a criminal history record check has been submitted to OMH on or after April 1, 2005.

Name of Authorized Party _____

OMRDD Secure Message ID _____

Signature of Authorized Party _____ Date _____

Criminal History Record Check Consent Form

NYS Office of Mental Retardation and Developmental Disabilities
Criminal Background Check Unit
PO Box 3005
Schenectady, NY 12303-0005
cbc.unit@omr.state.ny.us

The purpose of this form is to verify that the applicant understands and consents to the criminal history record check process.

Instructions:
1. Applicant must complete all fields on this form. Please print legibly.
2. Submit to Agency/Registered Provider/DDSO to retain.

Last Name	First Name	MI

Date of Birth	Social Security Number

Street Address or PO Box (applicant's)

City	State	Zip

PLEASE READ EACH STATEMENT BEFORE SIGNING

By signing this consent form I am acknowledging that I understand and consent to the following statements:

1. I understand that _____ (agency/DDSO/registered provider) is required/authorized by New York State Mental Hygiene Law 31.35 and Executive Law 845-b to request a check of my criminal history record.

2. Criminal history record checks are requested from the New York State Division of Criminal Justice Services (DCJS) and the Federal Bureau of Investigation (FBI). The OMRDD CBC Unit is authorized to receive the results of the criminal history record check and to develop a summary of the results. The summary will indicate:
   - whether I have a criminal history record, as maintained by DCJS and/or the FBI;
   - specific crimes for which I was convicted (felony or misdemeanor) or criminal charges which do not reflect a disposition;
   - the date of the criminal charge or conviction; and
   - the jurisdiction in which the charge or conviction took place.

3. I hereby consent to the OMRDD CBC Unit providing the summary of my criminal history record information, which includes information from both DCJS and the FBI, to the agency/DDSO listed above.

4. If I am an applicant for employment, I may withdraw my request without prejudice at any time before my application is accepted or declined regardless of whether my criminal history record information has been reviewed.

5. I have been informed that I have the right to obtain, review and seek correction of my criminal history record information under regulations and procedures established by the New York State Division of Criminal Justice Services and the Federal Bureau of Investigation.

6. I have been informed of the reason for the request for my criminal history record information and consent to having my fingerprints taken for the purpose of a criminal history record check by the New York State Division of Criminal Justice Services (DCJS) and the Federal Bureau of Investigation (FBI).

Signature _____ Date _____

Signature _____ Date _____
(of parent or legal guardian if applicant is under 18 years)

PROGRAM_CODE	PROGRAM_NAME
0053	Community Residence Part 671 – Residential Habilitation
0060	Crisis Intervention
0070	Summer Camp
0080	Residential School
0090	Intermediate Care Facility (30 beds or less)
0091	TUBS – Intermediate Care Facility (30 beds or less)
0100	Clinic Treatment Facility (Free-Standing Clinic)
0101	Clinic Treatment Facility (Clinic Joint Venture)
0120	Specialty Clinic
0150	Family Support Services
0190	Program Development Grants
0200	Day Treatment
0202	Day Treatment Partial
0212	HCBS Day Habilitation Service
0213	HCBS Prevocational Services
0214	HCBS Supported Employment
0215	HCBS Environmental Modifications
0216	HCBS Adaptive Technologies
0219	HCBS Residential Habilitation Service (At home)
0220	HCBS Residential Habilitation Service (Family Care)
0221	HCBS Assistive Supports
0222	Other Service Coordination (Non-Medicaid)
0229	Medicaid Service Coordination (MSC)
0231	HCBS Supervised IRA (Room & Board & Residential Habitation Services
0232	HCBS Supportive IRA (Room & Board & Residential Habitation Services
0233	HCBS Freestanding Respite
0235	HCBS Hourly Respite
0330	Day Training
0340	Sheltered Workshop/Certified Work Activity
0360	Classroom Education
0370	Preschool Program
0380	Transitional Employment Placement
0390	Supported Employment (non-HCBS waiver)
0400	Prevocational (non-HCBS waiver)
0410	Individualized Support Services
0411	HCBS Consolidated Supports and Services
0413	HCBS Family Education and Training
0414	Epilepsy Services
0416	HCBS Waiver Plan of Care Support Services
0610	Recreation
0630	Homemaker/Housekeeping Services
0650	Respite Care
0670	Transportation
0750	Information and Referral
0810	Case Management
0880	Subcontract Service
0890	Local Governmental Unit (LGU) Administration
1053	Community Residence Part 671 Supportive –Residential Habitation
1090	Intermediate Care Facility (over 30 beds)
1150	Traumatic Brain Injury (TBI)
1190	Special Legislative Grants
1220	HCBS Care at Home –III
1670	Integrated Employment Transportation
1850	Voluntary Preservation Project
2090	VOICF/DD, Sheltered Workshop
2091	VOICF/DD, Sheltered Workshop (not operated by service provider)
2190	Developmental Disabilities Program Council Grants
2220	HCBS Care at Home – IV &VI
3070	Shelter Plus Care Housing
3090	VOICF/DD, School District Contract
4090	SOICF Sheltered Workshop/Day Training
5090	VOICF/DD Day Training
5091	VOICF/DD Day Training (not operated by a service provider)
6090	Day Program Service Included in ICF/DD (On-site)
6091	Day Program Services Included in ICF/DD (Off-site)