

# Required Paperwork Help Sheet

	Page 2: 2024-2025 Kenston Local School District Calendar- I will include this separately
	Page 3: Absence Policy Reminder
	Page 4-5: Medical Authorization Record- this form only needs to be completed if your student needs to take medicine during the school day! Please remember that this form must be signed by the prescribing physician!
	Page 6-7: Emergency Medical Authorization: We need this form completed for all students at the beginning of each year!
	Page 8-9: Acceptable Use Policy: Please sign and return this document as it is required for all students
	Page 10: Transportation Permission: required for all students
	Page 11: Parent/Guardian Communication Information: required for all students
	Page 12: Photography/Publication Permission Sheet: required for all students
	Page 13: Student Cell Phone Use Policy: required for all students
provi	Page 14: Release of Information from a healthcare provider to Gaitway High School:  This form will need to be completed should you want to share any information with us from a healthcarder.
	Page 15/16: Gaitway Dress Code Guidelines and Parent/Student Acknowledgement Sign Off
	Fieldstone Farm Barn Paperwork (Pages 1-9) This is required for all students.
	Addendum: Kenston Schools Calendar that we follow
_	Addendum: Inhaler Self Carry Contract: Only required for those students who need this document





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15	16	17	18	19	20	21		10		Records Day	9	10	11	12	13	
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27	28	29	30	31							47	20	27	30		
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#### **Absence Policy Reminder**

If your child will be absent from school for any reason, please call:

440-708-0013 ext. 152

You can report your child's absence through email:

We must receive a court or doctor's excuse in order for your child to have their absence excused. If we do not receive a signed/documented excuse, we will be recording your child's absence as unexcused. This will count towards your child's total hours of lost attendance. Please let me know if you have any questions or concerns about this attendance policy.



Dear Parent or Guardian,

Attached to this year's Gaitway paperwork is a MAR form (Medication Administration Record). This form must be completed if your child is required to take medication during the school day. Students are not permitted to self administer any medication during the school day. Gaitway High School staff cannot administer any medication until this form has been completed.

Please fill out the form completely and sign the appropriate locations at the bottom of the form. You will notice that the second section of the form requires prescriber information. This portion must be completed by the prescribing physician! You will need to have a separate completed form for each medication. Finally, all medication must be in its original container!

It is important that you allow enough time for the physician's office to complete the paperwork so that it can be submitted to the school office with all appropriate signatures. Again, the Gaitway High School staff cannot administer medication(s) until the MAR form has been completed and signed by both the parents/guardians and the prescribing physician! If this notice does not pertain to your child, please disregard this form entirely.

All the best,

Principal: Gaitway High School

# Medication Administration Record (MAR) General Medication Form

(Including Asthma Inhaler and Epinephrine Autoinjector Use)

Student Information

Student Information							
Student name						Date of birth	
Student address							
School	Grade/Class	Teacher				School year	
List any known drug allergies/reactions		<u></u>		Height		Weight	
rescriber Authorization							
Name of medication		Circumstan	ice for use				
Posage Route Time/Interval							
Date to begin medication		Date to end	d medication				
Circumstances for use							
Special instructions							
Treatment in the event of an adverse reaction							
Epinephrine Autoinjector  Not applicable  Yes, as the prescriber I have determine with training in the proper use of the a		is capable of p	ossessing and using this	autoinjector appr	opriately and	have provided the student	
Asthma Inhaler Not applicable Yes, if conditions are satisfied per ORC 3317.716, the student's school is a participant.		ess and use th	e inhaler at school or at a	ny activity event	or program s	ponsored by or in which the	
Procedures for school employees if the student is unable to administe	r the medication o	or if it does no	ot produce the expected	d relief			
Possible Severe Adverse Reaction(s) per ORC 3317.716 and 3313.718 a) To the student for whom it is prescribed (that should be reported to the	ne prescriber)						
b) To a student for whom it is not prescribed who receives a dose			-				
Other medication instructions  Does medication require refrigeration?   Yes No Is the me	dication a controlled	d substance?	☐ Yes ☐ No				
Prescriber signature		Date		Phone		Fax	
Prescriber name (print)				I			
Reminder note for prescriber: ORC 3313.718 requires backup epinephrine	autoinjector and be	est practice rec	commends backup asthm	na inhaler.			
Parent/Guardian Authorization							
☑ I authorize an employee of the school board to administer the above dosage of medication is changed. ☑ I also authorize the licensed he	e medication. ☑ I un althcare professiona	nderstand that al to talk with t	additional parent/prescri he prescriber or pharmac	iber signed staten ist to clarify medi	nents will be r cation order.	necessary if the	
Medication form must be received by the principal, his/her designee, and/or the school nurse. It lunderstand that the medication must be in the <b>original</b> container and be properly labeled with the student's name, prescriber's name, date of prescription, name of medication, dosage, strength, time interval, route of administration and the date of drug expiration when appropriate.							
Parent/Guardian signature	Date	#	11 contact phone	· -	#2 contact	phone	
Parent/Guardian Self-Carry Authorization				-			
☐ For Epinephrine Autoinjector: As the parent/guardian of this student, I oprogram sponsored by or in which the student's school is a participant medication is administered. I will provide a backup dose of the medicat	I understand that a s	school employe	e will immediately request	ctor, as prescribed assistance from a	at the school in emergency	and any activity, event, or medical service provider if this	
☐ For Asthma inhaler: As the parent/guardian of this student, I authorize or in which the student's school is a participant.	my child to possess a	and use an asth	ma inhaler as prescribed, c	at the school and a	ıny activity, ev	ent, or program sponsored by	
Parent/Guardian signature	Date	#	1 contact phone		#2 contact p	phone	



# **Emergency Medical Authorization**

Revised 5/6/2020

This form meets the requirement for Ohio Revised Code Section 3313.712. Programs may use this form or build their own. Program Name Student Name \_\_\_\_\_ Phone \_\_\_\_\_ Purpose - To enable parents and guardians to authorize the provision of emergency treatment for children who become ill or injured while under school authority, when parents or guardians cannot be reached. Residential Parent or Guardian: Mother's Name \_\_\_\_\_ Daytime Phone \_\_\_\_\_ Father's Name \_\_\_\_\_\_ Daytime Phone \_\_\_\_\_\_ \_\_\_\_\_Daytime Phone \_\_\_\_\_ Other's Name Name of Relative or Childcare Provider Relationship \_\_\_\_\_ Daytime Phone \_\_\_\_ Emergency Contact<sup>1</sup> #1 \_\_\_\_\_\_ Daytime Phone \_\_\_\_\_ Emergency Contact #2 \_\_\_\_\_ Daytime Phone \_\_\_\_\_ Address Emergency Contact #3 Daytime Phone \_\_\_\_\_

<sup>&</sup>lt;sup>1</sup> Emergency contact information is required in accordance with Ohio Administrative Code Rule 3301-37-08 (for preschool programs) and Rule 3301-32-10 (for school aged child care programs).



ocal hospital to be called:	consent for the following medical care providers an
Doctor	Phone
Dentist	Phone
Medical specialist	Phone
ocal Hospital	Emergency Room Phone
cover major surgery unless the medical opinions concurring in the necessity for such surgery, are	o obtained prior to the performance of such surgery.  uding allergies, medications being taken, and any
	Date
PART II - REFUSAL TO CONSENT I do NOT gi child. In the event of illness or injury requiring take the following action (written instructions mu	ive my consent for emergency medical treatment of memorgency treatment, I wish the school authorities to ust be completed):



#### **INTERNET ACCEPTABLE USE POLICY (AUP)**

Parents or Guardian: Please read the following permission form carefully!

This permission form is required for your child to use the school's access to the Internet, through the Gaitway High School. Each student and his or her legal guardian must sign this Acceptable Use Policy (AUP) after having read the document and agreeing to adhere to the document's content when using a school Internet connection. Please read this entire application thoroughly! Students will have access to the Internet, an electronic highway connecting millions of computers all over the world and millions of individual subscribers. The user's agreement indicates acknowledgment and acceptance of the risks and regulations for computer and online use.

This is the communication medium of the twenty-first century; we in Gaitway High School are excited to provide Internet access to students. The educational resources now available to our students are impressive. With this access comes the availability of material that may not be of educational value in the context of the school setting. The Gaitway High School discourages access to controversial materials; however, on a global network, it is impossible to control all materials and a user may discover controversial information. Please Note: A filtering system is operating on all servers accessing the Internet for Gaitway High School. The valuable information and interaction available on the Internet far outweighs the possibility that users may procure controversial material. We urge you to discuss these issues with your child!

Students need to be aware that there is a consequence for inappropriate use of the Internet that will result in immediate loss of privileges, and future access to use the Internet through Gaitway High School will be denied. Each student must be aware this does not give unlimited access privileges to the student. The student receives authorization to visit web sites related to, and in support of, the curriculum and educational assignments given to the student. Your signatures on this agreement indicate you and your child have read the terms and conditions carefully and agree to those terms and conditions.

#### Terms and Conditions for Obtaining Internet Access

- 1. Acceptable Use Use of the Internet will be in support of the educational objectives of the Gaitway High School. Materials inappropriate in a school setting must not be obtained using this account.

  Transmission of any material in violation of the U.S. or state regulation is prohibited. This includes, but is not limited to: copyrighted material, threatening or obscene material, or protected by trade secrets.

  Commercial use of this account is prohibited. Obscene material, or material protected by trade secrets.

  Commercial use of this account is prohibited.
- 2. Privileges The use of the Internet is a privilege, not a right, and inappropriate use will result in a cancellation of those privileges. This network access to the Internet is designed for educational purposes consistent with the educational objectives of the Gaitway High School.



- 3. Network Guidelines The student is expected to abide by the generally accepted rules of network etiquette. This includes, but is not limited to the following:
  - The system shall be used for purposes related to the Gaitway High School educational objectives and in support of the academic program.
  - Do not "share" your account with others. Sharing of accounts may result in a loss of network privileges.
  - Use appropriate language. Do not curse, use vulgarities or any other offensive language.
  - Do not reveal your name, personal address, phone number or those of other students' colleagues, i.e., do not identify yourself.
  - All communications and information accessible via the network shall be assumed to be copyrighted.
  - Use of the computer and/or network is not for financial gain or for any commercial or illegal activity.
  - The administration reserves the right to monitor and/or restrict any computer activity and on-line communications for improper use.
- 4. Vandalism Vandalism will result in cancellation of privileges and possible legal action. Vandalism includes uploading/downloading any inappropriate or non-school related material, creating computer viruses and/or any malicious attempt to harm, alter or destroy equipment, materials or the data of any other user.

Student Signature Signifying Agreement to Comply with Acceptable Use Policy:

DDINIE Ctudont Nome

I understand and will abide by the Acceptable Use Policy (AUP) guidelines listed in this document. Should I commit any violation, my access to the school's Internet network may be revoked. I further understand that any violation of the policy guidelines is unethical and is cause for school disciplinary review and/or appropriate legal action.

PRINT Student Name.	
Grade:	Date:
User's Signature:	
Parent/Guardian Signature Signif Signature of Parent/Guardian	ying Agreement to Comply with Acceptable Use Policy:
(Mho actual signed AIID form will w	Date: emain on file in the Gaitway High School files)



Dear Parents and Guardians,

Gaitway High School staff has been certified, by the State of Ohio, to transport students in our Gaitway School van. This van allows the vocational program to travel to a variety of locations. The van also allows Gaitway the flexibility to transport students to field trip locations for school purposes and student rewards. To ensure safety of all of our students, we are using this permission form so that we know you have given permission for your child to ride in this school transportation vehicle with our licensed driver. Please let us know if you have any questions or concerns about this permission slip.

Thank you,
The Gaitway Principal

# <u>VAN PERMISSION SLIP</u> <u>Please sign either yes or no below and return</u>

Yes, I give my permission for my child to ride in the Gaitwa special trips for lunches/positive reinforcement.	y High School van for job training, field trips, an
Student Name	_
Parent/Guardian Signature	
No, I do not give permission for my child to ride in the Gait and special trips for lunches/positive reinforcement.	way High School van for job training, field trips,
Student Name	
Parent/Guardian Signature	



### PARENT/GUARDIAN COMMUNICATION INFORMATION

**STUDENT NAME:** 

<u>Parent/Guardian</u> <u>Name</u>	Primary Phone	Alternate Phone	<u>Primary Email</u>	Number to text



	<u>Photography/Pu</u>	<u>blication Permission</u>
lease	initial if you grant/decline permission for each r	number listed below:
1.	My child's photo may be used for program purp	oses.
(	Grant Permission	Decline Permission
2.		ay be used in press releases, brochures, newspapers, slides, ners regarding the ESC of the Western Reserve's programs
ļ	Grant Permission	Decline Permission
3.	My child's photo may be used on the ESCWR we	bsite.
ļ	Grant Permission	Decline Permission
4.	My child's photo may be used in the Gaitway Vidand posted on our website.	deo Yearbook which is played at our graduation ceremony
	Grant Permission	Decline Permission
unde nore	erstand that it is my responsibility to update this for the above uses. I agree that this form will rema	orm in the event that I no longer wish to authorize one or in in effect during the 2023-2024 school year.
ζ		(Parent/Guardian
igna	ture)	



#### Student Cell Phone Policy for Gaitway and Job Training

- 1. Students should only make personal cell phone calls during classroom breaks or lunch time. In the event of an emergency, students should seek permission from a Gaitway staff member to make a call.
- 2. Frequent or lengthy phone calls are not acceptable as they may adversely impact productivity and disturb others.
- 3. Students should only use their cell phone for personal text messages or social media only during classroom breaks or at lunch. In the event of an emergency, students should seek permission from classroom staff in order to send a text message.
- 4. Students should be encouraged to use common sense when making or receiving personal cell phone calls during the day. For example, students should speak quietly and reserve personal information or intimate details for non-school hours.
- 5. Personal cell phone use, even when permitted, must never include language that is obscene, discriminatory, offensive, prejudicial, or defamatory in any way. This includes jokes, slurs, and/or inappropriate remarks regarding a person's race, ethnicity, sexual identity, sexual orientation, religion, color, age, or disability.
- 6. Students should always turn off ringers or change ringers to "mute" or "vibrate" during designated school hours.
- 7. Students are prohibited from using cell phone cameras to record videos or take pictures of other students. This is a violation of our students' privacy. Disciplinary actions may result from unauthorized use of a student cell phone to record videos or take pictures.
- 8. Students who are observed on their cell phones without permission during the school day will be asked to give their device to the teacher. We will utilize the ASK, TELL, TAKE, standard each time.

By signing this document, I agree and will follow this policy when at Gaitway High School or at Job Training sites:
Student's signature/date
Printed Student's Name:
Parent/Guardian Signature/date:



#### AUTHORIZATION TO RELEASE PERSONAL INFORMATION FROM HEALTH CARE PROVIDERS TO GAITWAY

<u>Section 1: Student Information -</u> This form provides authorizat student:	on related to the personal health information of the following
Name: Date or	f Birth:
Address: Telepho Section 2:Disclosure of Use of Personal Health Information: I h	one: nereby give my permission to :
manner described below.  Section 3: Description of Personal Health Information to be dis	name) to use and disclose my personal health information in the sclosed:  be disclosed (i.e. all medical records related to treatment for ADHD
Educational/Emotional/Behavioral information Section 4: Description of Persons or Entities Authorized to Rec Authorized representatives at Gaitway High School located at 1 number of: 440-708-0013 have my permission to receive and the second	6497 Snyder Road, Chagrin Falls, Ohio 44023 and the contact phon
Section 5: Purpose of this Authorization: The purpose of this of present and future educational decisions and to: support str	lisclosure of personal health information is to: aid in the making ategies/treatment plans at the school level.
Section 6: Expiration and Revocation: This authorization may be revoked or canceled at any time to the information prior to the revocation of this authorization. Requirements: KATHY SCHWELZER at GAITWAY HIGH SCHOOL at AA revoked, this authorization will expire one year from the date the	ests for revocation must be in writing. To revoke this authorization 0-708-0013 (Ext. 158) or at KSchmelzer@escwr.org. If not
Section 7: Signature and Refusal to Sign this Authorization: I acknowledge that this authorization is voluntary and that I am treatment unless such treatment is solely for the purpose of creatment authorization.	not required to sign this authorization as a condition of health care ating personal health information for disclosure to:
Signature:	Date:



#### Dress Code Guidelines 2024-2025

The Gaitway team expects student dress and grooming to be neat, clean, and of good taste so that each student may share in promoting a positive, healthy and safe atmosphere within the school. Its purpose is to emphasize that school is the student's place of work and that respect for other members of society and oneself places some restrictions on the nature of dress and grooming.

It is a mark of maturity when students can freely choose apparel that demonstrates individuality without deviating from the standard of appropriateness. Student dress and grooming will be the responsibility of the individual and his/her parents within the following guidelines:

- 1. Dress and grooming will be clean and in keeping with health, sanitary and safety requirements.
- 2. Students must wear acceptable footwear at all times.
- 3. No chains or spiked or studded jewelry may be worn.
- 4. Students shall not wear clothing or accessories bearing the following messages:
  - a. Obscene or profane statements or pictures;
  - b. Statements advocating immoral, illegal, sexual or violent behavior;
  - c. Statements advertising, promoting or picturing alcohol, tobacco or drugs;
  - d. Language or symbolism (including, but not limited to, swastikas, rebel flags, the occult or gang affiliation.)
- 5. Students shall not wear clothing that shows any of the following:
  - a. Boxers/Briefs/Underwear
  - b. Bras
  - c. Back
  - d. Belly/Stomach/Midriff
  - e. Backside/Butt/Bottom
  - f. Breast/Chest.
  - g. Bare/Nearly Bare Shoulders
- 6. Dress and grooming will not be such as to disrupt the teaching/learning process or cause undue attention to an individual student in that it substantially disrupts the school environment.
- 7. Class activities that present a concern for student safety may require the student to adjust his/her hair and/or clothing during the class period in the interest of maintaining safety standards.
- 8. Additional dress regulations may be imposed upon students participating in certain extracurricular Activities.



9. Regulations may be altered according to special school sponsored activities.

If, in the opinion of the administrators, any clothing or accessories are worn by students in violation of this policy, the students will be required to change or cover said clothing, or remove said accessories. Refusal to change or cover said clothing or accessories will result in a disciplinary action and a parent contact.

Students will also need to adhere to the dress code requirements for when they are in the Fieldstone Farm barn (safety), If students are enrolled in the Job Training class they will need to follow the Job Training dress code to go to work sites.

#### Fieldstone Farm - Barn requirements

- Sneakers and/or low heel boots, and a pair of winter work boots
- Shirts will be Gaitway attire (see above)
- No Shorts
- No Phones
- No Headphones
- No dangling jewelry on uncovered body

#### **Iob Training sites:**

- ESC Western Reserve polo shirt Gaitway will provide to students
- Black pants (No leggings or sweatpants)
- Black non-slip shoes
- Optional: White or Black, long sleeve t-shirt that can be worn underneath polo in winter
- No Hoodies
- No Hats
- No Headphones

#### Gaitway/Fieldstone Farm Dress Code Acknowledgement:

Parent/Guardian:	 	
Student:		



16497 Snyder Road Chagrin Falls, OH 44023 440.708.0013 Fax: 440.708.0029 programs@fieldstonefarm.org

### 2024 REGISTRATION

Participant:	D:	ate of Birth:	Age:
Street:			
City:	County:	Zip Co	ode:
Primary Phone:	cell or hom	ne <i>(circle one)</i>	
For adult participants: Secondary Phone	ż.	cell,	home or work <i>(circle one)</i>
Primary Email for Billing and Communica	ıtion:		
School or Institution presently attending:	e		<u>.</u>
Participant is a <i>(circle one)</i> : Minor	Adult w/a legal guar	dian Indep	endent adult
For new students: How did you hear abou	t us?		
For grant writing purposes only, please indic	ate participant's ethnic backg	round. Check any tha	t apply:
Caucasian Asian Hispanic/La	tino African American	Native America	n Other O
Is the participant a veteran or active milita	ary of the U.S. Armed Force	s? (Circle one): Y	es No
Branch of service:	•	•	
Dianell of service.			
For minors or adults with legal guardia	ns (Required):		
Parent or Guardian Name:	0	ccupation:	
Employer:	W	ork Phone:	
Cell Phone:	E	mail:	
Address if different than participant:	Re	lationship to particip	ant:
Other Parent or Guardian Name:	0	ccupation:	
Employer:		•	
Cell Phone:	E	mail:	
Address if different than participant or fir	st guardian:		
Relationship to participant:			
Please name any caregivers/phone number	s who may transport or be res	ponsible for Participa	nt:

Participant Name:	Date of Birth:
IN CASE OF EMERGENCY	
	Fieldstone Farm will provide basic first aid and/or call 911 and will disclose all available health care l.
Please list two Emergency Contact	names/phones:
Emergency Contact Name:	Phone:
Emergency Contact Name:	Phone:
Please noteany LIFE THREATEN	ING allergies (bees, asthma, medications):
PHOTORELEASE	
acknowledged, the undersigned he photographs, videos and films inc advertising agencies, news media, to use and reproduce the photog deemed appropriate by Fieldstone	reipt of which from Fieldstone Farm Therapeutic Riding Center and PATH Intl. is hereby grants to Fieldstone Farm permission to take, or have taken, still and moving tuding television pictures of myself and/or the participant for use by Fieldstone Farm, its and any other persons involved with Fieldstone Farm and its programs including PATH Intl., raphs, films, videos and pictures and to circulate and publicize the same by any means Farm, including without limitation newspapers, television media, online media, brochures, all materials, books and clinical materials.
Fieldstone Farm to use or cause to	be been made to me to secure my signature to this release other than the intention of be used such photographs, films, videos and pictures for the primary purpose of Farm and/or PATH Intl. and its programs.
I DO consen	IDO NOT consent
Date:	_Signature:

#### RELEASE AND HOLD HARMLESS AGREEMENT

The undersigned agrees on behalf of himself/herself, the undersigned's minor child and/or the undersigned's representatives, heirs and assigns ("Releasing Parties") to the following:

A. Fieldstone Farm Therapeutic Riding Center ("Fieldstone Farm") has fully explained to him/her the risks involved with horseback riding, carriage driving, showing horses, horse-related activities and/or being in close proximity of horses. These risks include but are not limited to: 1. the propensity of a horse to behave in ways that may result in bodily injury; physical harm, permanent disability; death, or loss to persons around the horses, including without limitation, the rider, driver, handler; and spectator; 2. the unpredictability of horse's reaction to sound, sudden movement, unfamiliar objects, persons, or other animals, which reaction may include but is not limited to changing speed or direction at will, shifting its weight, bucking, rearing, kicking, biting, running from danger, stepping on a person's feet, pushing or shoving a person; 3. hazards, including but not limited to surface and subsurface conditions, 4. collision with another horse, animal, person or object; and 5.the potential of the Releasing Parties, or any other person involved in an equine activity to act in a negligent manner that may contribute to injury, death permanent disability, or loss to any of the Releasing Parties or the other persons, including, but not limited to failing to maintain control over a horse or failing to act within the ability of the participant. The Releasing Parties each further understands that the horse is a prey animal and regardless of its calm nature and training, the horse may revert to its natural instinct to fight or flee when frightened, which may result in injury, death, permanent disability, or loss to you or other persons. By signing this Release, the Releasing Parties each assumes all of the dangers and risks associated with horse activities and being in close proximity of horses, including those risks enumerated above.

B. In consideration of the privilege of riding, handling, and working around and being in close proximity to horses at Fieldstone Farm located at 16497 Snyder Rd., Chagrin Falls, Ohio, the Releasing Parties each releases, discharges and promises not to sue Fieldstone Farm, or any of it employees, officers, directors, trustees, members, volunteers, successors and assigns for any loss, damage, injury, including death or cost to any of the Releasing Parties or persons accompanying any of the Releasing Parties arising out of riding, handling or being in close proximity of horses and equine activities, including without limitation failing to wear a protective helmet and or use of saddles, bridles, helmets, equipment and gear provided by Fieldstone Farm or any other person or entity. The Releasing Parties also each agrees to discharge, release and promises not to sue Fieldstone Farm from any claim arising from Fieldstone Farm's training or selecting of the horses, maintenance, care, fit or adjustment of saddles or bridles, instruction on riding and related skills or leading or supervising Releasing Parties in his/her riding and other equine activities, including without limitation non-riding activities such as handling, bathing and grooming horses.

C. The Releasing Parties each agrees to indemnify and hold harmless Fieldstone Farm, its employees, volunteers, trustees, directors, officers, successors, assigns and students from and against any loss, liability, damage, expense or costs including attorney fees that it may incur or incurs arising out of or in any way connected with the Releasing Parties' participation in equestrian activities, including without limitation, handling or riding of horses or being in close proximity to a horse or due to the failure to wear a helmet when riding or handling and/ or use of saddles, bridles, equipment in connection with the equestrian activities. This indemnification provision shall survive the signing of this Release.

D. The Equine Liability Law, Ohio Revised Code Section 2305.321 generally states in part: Equine (Horse) Activity Sponsor is not liable in damages in tort or other civil action or harm that and Equine Participant allegedly sustains during an equine activity and that results from inherent risk of equine activity.

Signature	Date
Print Name	
Name of minor child (if applicable)	

# **HEALTH HISTORY**

Partici	pant's name:		Date of Birth:
Heigl	nt (Required):	***	Weight (Required):
Gende	er (Circle one, Required): Woman/Girl Man/Boy	/ Transger	nder Nonbinary/Nonconforming Other Prefer Not to Share
grant fo		ith cancer or	nts and families we serve. We may have an opportunity to apply for a who have a family member who has been diagnosed with cancer. If ncer diagnosis? (Circle one) Yes No
List <u>A</u>	LL Diagnoses or Disabilities (Required):		Date of Onset (year):
	enswer to any of the following HEALTH QUES		YES, a Physician's Release form (p.7) is required.
Yes	paraopanto, a ocer a anceroz ary or are reasoning.	Date	Details
	Downsyndrome		
	Spinal condition i.e. injury, scoliosis, fusion, Spina Bifida		
	Brain condition i.e. Cerebral Palsy, stroke		
	Bleeding or clotting disorders		
	Diabetes		
	Joint complications such as hip dysplasia		
	Epilepsy		Date of most recent seizure:
	Heart condition including pacemakers		
	Neurological condition i.e. hydrocephalous, mitochondrial disorder		
	Pulmonary condition		
	Skin break down or pressure sores		
	Medical shunt or any type of feeding tube		
In	the past 12 months, has the participant experienced:		
1.	Loss of consciousness, including seizures:		Yes
2.	Any seizure activity for any reason		Yes
3.	Hospitalization for a mental health crisis:		Yes
4.	Hospitalization for any serious injury, condition or surg	gery	Yes
5.	Activity restrictions due to medical reasons:		Yes
6.	The need for assistance to maintain an upright sitting p	osition or co	ontrol of the head: Yes
7.	A medical device such as an insulin pump, catheter,	or colostor	my bag: Yes
If Yes	to any of the questions above please provide date ar	nd details: _	

And complete a required Physician's Release (pg. 7)

	Yes Yes		Details	<del></del>	
Hearing					
Vision					
Speech					
Immune deficiency					
Circulation					
Cognitive Development				·· <u>-</u>	
Pulmonary					
Fatigue or limited endurance					
Muscular					
Orthopedic (incl. spine & joint	s)				
Emotional or Psychological					
Behavior					
Broken bones			-		
Other					
Medications:			47-64		
Allergies:					
oes the participant have or use:  Asthma Yes	Walker	Yes			
oes the participant have or use:  Asthma Yes  EpiPen Yes		Yes			
oes the participant have or use:  Asthma Yes	Walker Crutches	Yes Yes	Describe		
Asthma Yes EpiPen Yes Inhaler Yes	Walker Crutches Wheelchair Body brace of any ty	Yes Yes pe Yes		rect.	
oes the participant have or use:  Asthma Yes  EpiPen Yes	Walker Crutches Wheelchair Body brace of any ty	Yes Yes Pe Yes  Alth history info	rmation is complete and cor	rect.	

IMPORTANT: Fieldstone Farm reserves the right to request additional information and/or an evaluation by the participant's licensed medical professional prior to or during the course of equine-assisted programming and/or to restrict or offer alternative activities until such information or evaluation is procured.

# Fieldstone Farm Student Goal Checklist

tudent name:		
lge:	_ Date:	
rimary Diagnosis:		
econdary Diagnosis:		
orm completed by:		
to structure our lesson plans. Examples as What is a major life goal?	re: walking without assistance, inde	
Please rank the goals in each category you/your student. Rank them 1 throug		cognitive goals - as you feel they are important to ant.  Cognitive Goals
Balance	Socialization	Readiness skills
Posture	Enjoyment	Verbal skills/Vocalizations
	Participation	Vocabulary Expansion
	Sportsmanship	Word Recognition/ Reading
		skills
		Math Skills
		Shape recognition     Color Identification
Coordination	Confidence	Decision making
Fine Motor Skills	Self-esteem	Sequencing
Range of Motion	Responsibility	- ocquencing
Spatial Awareness	Independence	
Strength	Communication	Concentration
Head Control	Cooperation	Focus
Gross Motor Skill	Transition	Attention (increase)
Muscle tone (increase)	between	Attention (decrease)
Muscle tone (decrease)	activities	
Other: Oth	er: (	Other:
		nmend instructors use in the barn and during less
i incoded, what behavior modification teem	inques would you suggest of fectil	minima minimanono mon mi dio main ana mainig todo
he participant is experiencing a challenge?		



16497 Snyder Road Chagrin Falls, OH 44023 440.708.0013 Fax: 440.708.0029 programs@fieldstonefarm.org

# PHYSICIAN'S RELEASE

This form is required if:  Participant has Down syndrome or seizure activity	
☐ If one or more of the HEALTH QUESTIONS on page 4 are answered YES	
ParticipantName:	Date of Birth:
Parent/Guardian Name:	Phone:
PHYSICIAN'S REPORT <b>MEDICAL</b> (if not within normal ranges,	
Appearance and Affect	
Eyes/Ears/Nose/Throat	
Lymph Nodes	
Pulses	
Heart	
Lungs	
Abdomen	
Skin	
Neurologic	
MUSCULOSKELETAL	
Neck	
Back	
Upper Extremities	
Lower Extremities	
FOR PERSONS WITH DOWN SYNDRO	OME CONTROL OF THE CO
Does this patient have symptoms consistent with atlantoaxial instability? Yes	No DATE OF EXAM:
FOR PERSONS WITH SEIZURE ACTIV	TTY
Does this patient still require close supervision due to seizure symptoms? Yes	No
PHYSICIAN'S RELEASE	
I have examined the above-named participant and, given the participant's diagnosi	s and health history, this person
does not present apparent clinical contraindications for equine sports. I understand t	hat Fieldstone Farm will weigh the
medical information provided against the existing precautions and contraindications	; therefore, I refer this person to
Fieldstone Farm for ongoing evaluation to determine eligibility for participation.	
Physician's Signature:	
Physician's Name (please print):Ph	one:
Address/City/Zip:	

#### SEIZURE EVALUATION FORM

Complete the following form if the participant has experienced seizure activity within the past 3 years. Seizure paperwork must be completed every 6 months for all participants who have had a seizure or seizure activity in the calendar year. If the participant has been seizure-free for more than 3 years, Fieldstone Farm will not follow our active seizure-related procedures such as providing a volunteer spotter during mounted lessons.

Instructions: Please complete this form including as much information as possible. Since working around horses is a risk activity, conditions that increase that risk are carefully analyzed. The safety of all participants, volunteers and horses is considered.

Student's Name
Parent/Guardian Name
Parent/Guardian Preferred Phone
You are encouraged to consult with the physician who manages your or your child's seizure care when completing the following:
Type of Seizure (if more than one, please list all types)
Are you/Is your child under the care and treatment of a seizure physician (e.g a neurologist)?  Ves  No
Are you/Is your child taking medication to control the seizures?  Yes No
Date of Last SeizureFrequency of seizures
Duration of Average Seizure
Typical Causes of Seizure Activity
Seizure activity indicators: (aura, behaviors or manifestations of oncoming seizure activity)
Are you / is your child able to know when a seizure may occur? Can you / they express it? What are the signs?

During a seizur	e, I / my child:		
☐ May walk arou ☐ May perform a ☐ May suddenly ☐ May experience	imless activities cry / fall / become rigid, followed c loss of bladder or bowel control ed, have a headache, be fatigued; f	by muscle jerks / saliva on lip	
After Affect			
Current Medicat	ons		
Please note mos	recent seizure activity and incider	its with comments (add additi	onal rows as necessary)
Date/time	Details		Care provided
Date/time	Details		Care provided
Date/time	Details		Care provided
Date/time	Details		Care provided
what actions do  Call 9-1-1	or child experience a seizure while you suggest we take?	·	
Student/Parent	Guardian Date	Fieldstone Farm Staff	Date



# 2024-2025 CALENDAR (APPROVED: 9/18/23)

### LEGEND:

No School

Start/End of School

July 2024						
S	M	Т	W	τ	F	S
18	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29	30	31			ary.
50						211

Ī	1-	No Colonel	January 2025						
	3	No School	S	М	T	W	T	F	S
	3	No School/ Teachers' Records				. 1	2	3	4
	3	Day	5	6	7	8	9	10	11
ſ		Return from Winter	12	13	14	15	16	17	18
L	•	Break	19	20	21	22	23	24	25
	20	MLK Jr. Day	26	27	28	29	30	31	'ini'
L									231

S	M	T	W	T	F	S
				1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29	30	31

12	1st Days – Teacher
	Work Day
13	1st Days – Teacher
	PD Day
14	1st Days Teacher
	Work Day
15	1º Day - Students
30	No School/Fair Day
	· ·

			Fe	bru	ary	20	25	
14	No School – Teachers' PD Day	S	S M T W					
17	No School/	2	3	4	5	6	7	
	Presidents' Day	9	10	11	12	13	14	
		16	17	18	19	20	21	
		23	24	25	26	27	28	
L		150						

S	M	ī	W	T	F	S
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30					

2	No School/Labor Day

6 ,	End of 3 <sup>rd</sup> Quarter = 42 Days
7	No School - All Staff Workday; Teachers: ½ PD Day, ½ Records Day
24	No School/Spring Break Begins
31	School Resumes

March 2025							
S	М	Ţ	W	T	F	S	
dis						1	
2	3	4	5	6	7	8	
9	10	11	12	13	14	15	
16	17	18	19	20	21	22	
23	24	25	26	27	28	29	
30	31						

T W T F S

4 5 6 7 8 11 12 13 14 15 18 19 20 21 22 25 26 27 28

S	M	T	W.	T	F	S
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30	31		

3	No School/ Rosh Hashanah
10	End of 1st Quarter = 39 Days
11	No School – Teacher 1/2 Day Records Day

			April 2025						
18-	No School	S	M	Ţ	W	T	F	S	
21		1113		1	2	3	4	5	
1		6	7	8	9	10	11	12	
		13	14	15	16	17	18	19	
		20	21	22	23	24	25	26	
	<u> </u>	27	28	29	30			53	
								61	

November 2024								
	S	М	T	W	Ŧ	F	S	
						1	2	
	3	4	5	6	7	8	9	
	10	11	12	13	14	15	16	
	17	18	19	20	21	22	23	
	24	25	26	27	28	29	30	

27	No School/ Conference Break
28	No School/ Thanksgiving
29	No School/ Thanksgiving Break

	26	No School/Mem Day		
	28	Last Day – Students End of 4th Qtr = 50 Days End of 2nd Semester	4	<b>M</b>
ı		= 92 Days	11	12
	29	No School/Last Day – Teachers (½ Records	18	19
	27	Day)	25	26

May 2025							
S	М	T	W	T	F	S	
				1	2	3	
4	5	6	7	8	9	10	
11	12	13	14	15	16	17	
18	19	20	21	22	23	24	
25	26	27	28	29	30	31	

December 2024							
S	M	ĭ	W	T	F	S	
1	2	3	4	5	6	7	
8	9	10	11	12	13	14,	
15	16	17	18	19	20	21	
22	23	24	25	26	27	28	
29	30	31					

-		
		End of 2nd Quarter
	20	= 47 Days
		End of 1st Semester
		= 86 Days
	23	No School/Winter
	23	Break Begins

		Jun	e 2	025		
 S	М	T	W	T	F	S
 1.	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30					Z

Asthma Self Carry Contract	School:	Grade:						
STUDENT :		DOB:						
☐ I plan to keep my rescue inh	aler with me at scho	ool rather than in the school health office.						
■ I agree to use my rescue inhaler in a responsible manner, in accordance with my physician's orders.								
□ I will notify the school health office if I am having more difficulty than usual with my asthma.								
☐ I will not allow any other per	son to use my inhal	er.						
Student's Signature		Date						
PARENT/GUAR	RDIAN:							
This contract is in effect for the student fails to meet the above	•	r unless revoked by the physician or the es.						
□ I agree to see that my child carries his/her medication as prescribed, that the device contains medication, and the date is current.								
☐ It has been recommended to Office for emergencies.	me that a back-up	rescue inhaler be provided to the Health						
I .		vith the student on a regular basis as						
		signed medication authorization for this						
medication. Parent's Signature		Date						
Nurse Consultant		School						
	ne and dosages, and	chnique for inhaler use, an understanding d an understanding of the concept of						
☐ School staff that have the ne carry medication have been		he student's condition and the need to						
care provider.								
Nurse Consultant's Signature		Date						

School Administrator's Signature:	Date:			
Teacher's Signature:	Date:			
Teacher's Signature:	Date:			
Health Assistant Signature:	Date:			
Allergy Self Carry Contract School:	Grade:			
STUDENT:	DOB:			
☐ I plan to keep my Epi-pen with me at school rather that	n in the school health office.			
■ I agree to use my Epi-pen in a responsible manner, in orders.	accordance with my physician's			
☐ I will notify the school health office immediately if my E	Epi-pen has been used.			
☐ I will not allow any other person to use my Epi-pen.				
Student's Signature	Date			
PARENT/GUARDIAN:				
This contract is in effect for the current school year unless student fails to meet the above safety contingencies.	ss revoked by the physician or the			
■ I agree to see that my child carries his/her medication contains medication, and that the medication has not e				
☐ It has been recommended to me that a back-up Epi-pe for emergencies.	en be provided to the Health Office			
☐ I will review the status of the student's allergy with the agreed in the health care plan.				
I will provide the school a signed medication authoriza	ation for this medication.			
Guardian's Signature	Date			
Nurse Consultant	_ School			

☐ The above student has demonstrated correct technique for Epi-pen use, an understanding of the physician order for emergency use of the Epi-pen .						
<ul> <li>School staff that have the need to know about carry medication have been notified.</li> <li>I will review the medication authorization provided.</li> </ul>						
and health care provider.						
Nurse Consultant's SignatureDate						
School Administrator's Signature:	Date:					
Teacher's Signature:						
Teacher's Signature:	Date:					
Health Assistant Signature: Date:						
Tealth Assistant Signature Date						