

The EAL Approach

An Introduction to Equine-Assisted Learning for Health, Counseling & Equine Professionals



Three dates available for 2016:



April 24th * May 15th * Jun 5th
Each workshop - 12-4pm (11:45am check-in)

Horses have been described as dynamic, graceful and gentle. We seem to be naturally drawn to their quiet strength. It is the horses' sensitive and intuitive nature which allows them to mirror the feelings of others, providing valuable information about ourselves.

Equine-Assisted Learning is gaining popularity as a unique and effective approach of incorporating experiential learning with horses to help individuals with emotional challenges such as trauma, anxiety and depression. Enjoy an afternoon of hands-on activities with Hidden Acres staff and therapy horses. Learn the benefits of EAL and how mental health and equine professionals can partner in the care of clients through supportive equine-assisted activities. Learn how horses can help clients develop:

From a Counseling Professional –
“This was one of the most incredible experiences. The horses are such beautiful beings and transform, shift, energy in ways that are so natural.”

A great workshop for those interested in learning more about the field of EAA or referring others for services. The experiential activities will be supported with discussion and handouts.

- Greater self-awareness
- Empathy and compassion
- Intention & mindfulness
- Effective communication
- Trust-based relationships
- Awareness of patterns in relationships

Join us at Hidden Acres Farm, 45 Gabriel Dr., Naugatuck, CT

Experience with horses is not required. Workshop attendees will take part in hands-on ground exercises (not riding) guided by Rebecca Caruso, LCSW/PATH instructor, and Jeanna Pellino, PATH Instructor/Equine Specialist. To register, complete bottom portion & return with payment. Workshop cost: \$125 per person. (4 NESW CEUs for LMFT,SW, LPC, and licensed psychologists)

COMPLETE AND RETURN BOTTOM PORTION

Please register me for the EAL Workshop for professionals (check one): Apr 24th May 15th Jun 5th

Name: _____ tel. _____

Address: _____ Zip _____

Email _____ Occupation _____

(select one) I have no horse experience Some horse experience Significant horse exp.

Please make check payable & return to: Hidden Acres TRC, PO Box 1879, Naugatuck, CT 06770

www.hiddenacrestrc.org

**HIDDEN ACRES THERAPEUTIC RIDING CENTER, LLC
SPECIALTY PROGRAM
LIABILITY RELEASE & AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT**

Participant Name: _____ D.O.B. _____ Age: _____
Weight: _____ Height: _____ Diagnosis/Disability(if applicable): _____
Street Address: _____ Town _____ zip _____
Home Phone: _____ Cell _____ Email _____
Parent/Guardian/Contact Name: _____
Billing address (if different from part.) _____
School/ Institution Presently Attending: _____ How did you hear about us: _____

Demographic Info. As a non-profit, Hidden Acres relies on funding sources that require this information.
Please check: Male Female Veteran yes No
Household Income: below \$15,000 \$15,000-24,999 \$25,000-39,999 \$40,000-54,999 \$55,000+
Ethnicity: white African-Amer. Asian Nat. Amer. Hispanic Other

EMERGENCY INFORMATION - In the Event of an Emergency:

Preferred Medical Facility: _____
Primary Emergency Contact: _____ Relationship: _____
Phone: () _____ Alternate name &ph: _____
Health Insurance Co: _____ Policy #: _____

Please list any food or other allergies, medications, or current health concerns: _____

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT & CONSENT PLAN

In the event that 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 Hidden Acres Therapeutic Riding Center to: Secure and retain medical treatment and transportation, if needed and release client records upon request to the authorized individual or agency involved in the medical emergency treatment. 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) listed cannot be reached.

Date: _____ Consent Signature _____
Client, parent or legal guardian

PHOTO & PR RELEASE (please check one) I hereby consent to and authorize, or I do not consent to, nor do I authorize, the use and reproduction of any and all photographs and other audiovisual materials taken of me by Hidden Acres Therapeutic Riding Center, LLC for promotional printed material, educational activities, exhibitions, or for any other use for the benefit of the program.

Date: _____ Signature: _____
Client, parent or legal guardian

LIABILITY RELEASE (Required): _____ (Part.Name) would like to participate in the Hidden Acres Therapeutic Riding Center, LLC Program. I acknowledge the risks and potential for risks of horseback riding and equine activities including grievous bodily harm. However, I feel that the possible benefits to myself/my child/my ward are greater than the risk assumed. I hereby, intending to be legally bound for myself, my heirs and assigns, executors, and administrators, waive and release forever all claims for damages against Hidden Acres Therapeutic Riding Center, LLC its Board of Directors, Instructors, Therapists, Aides, Volunteers, and/or Employees for any and all injuries and/or losses I/my child/my ward may sustain while participating in the Program from whatever cause including but not limited to negligence of these released parties.

The undersigned acknowledges that he/she has read this Registration and Release for in its entirety; that he/she understands the terms of this release and has signed this release voluntarily and with full knowledge of the effects thereof.

Date: _____ Signature: _____
Client, parent or legal guardian