GAIT TRC
PO Box 69
Milford, PA 18337
570-409-1140 (phone)
570-300-2288 (fax)

gaitpa@gmail.com (email)
www.gaittrc.org (website)
www.facebook.com/GAIT.TRC

GAIT's MISSION:

To improve the quality of life of children and adults with special needs through equine activities and therapies, resulting in a more independent life in society.

Welcome to GAIT Therapeutic Riding Center!

GAIT TRC is a Premier Accredited Center with the Professional Association of Therapeutic Horsemanship International (PATH Int'l). PATH Int'l is *the* global accreditation body that sets the safety standards and requirements for the therapeutic riding industry worldwide.

As a Premier Accredited Center, GAIT TRC adheres to the highest safety standards and mandates. All equine sessions are conducted by PATH Int'l Certified Instructors, Equine Specialists, licensed therapists, credentialed mental health professionals, and highly trained volunteers.

GAIT TRC is a 501 (c)(3) non-profit organization that serves children and adults in the tri-state area, providing services at a portion of the actual cost. Fees from programs cover 30% of operation costs while 70% comes from grants and other donations, which care for a herd of 10 horses and ensure professional programs. Scholarships are available through privately funded grants such as the Jean Work Scholarship Fund and the Ingeborg A. Biondo Memorial Foundation.

Important Note:
These forms must be completed, signed, dated, and returned to GAIT TRC prior to the individual's first class or they will not be allowed to participate.

These forms are good for the current year only and must be renewed and returned to GAIT TRC annually. Applications for all programs are available via GAIT's website: www.gaittrc.org.

Policies of GAIT TRC

1. No smoking ANYWHERE on the premises.
2. Parking is available next to the barn or in the off street lot. In the event of inclement weather, parking is available by the Indoor Arena.
3. Parents/ legal guardians/ authorized caregivers are responsible for the supervision of participants and non-participants while at GAIT and must remain on the premises during the duration of the session.
4. To ensure the safety of our riders, horses, and volunteers, please refrain from using umbrellas while horses are in the arena. Also, loud noises such as shouting, clapping, or doors banging may distract the horses from giving your child a safe ride.

Policies continued on page 2……

GAIT
Therapeutic Riding Center

THERAPEUTIC SERVICES

Therapeutic Horseback Riding
Equine Assisted Learning
Hippotherapy
Equine Facilitated Psychotherapy
Vocational Training
Equine Services for Heroes

EDUCATIONAL PROGRAMS

Internship Program
Mentoring for Instructors in Training
OSWC Workshop & Certification
ESMHL Workshop & Skills Test

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Policies of GAIT TRC

Continued from page 1……

5. All mounted activities are limited to 180 lbs. weight limit (maximum weight GAIT's horses can carry). These restrictions do not apply to unmounted activities.

6. GAIT TRC requires all riders to be seen and examined by their personal physician each and every year BEFORE their first ride.

7. A physician must sign FORM 6 (Medical Clearance and Physician's Statement) and include participants' weight and height prior to riding.

8. All paperwork must be updated and returned to GAIT staff annually.

Please be sure your physician is aware of the participant's particular diagnoses for precautions and contraindications, whether it is shown on the below partial list or not. *If you have any questions regarding this, ask your physician*.

The following is a *partial list* of diagnoses of conditions, syndromes, disorders and problems as assessed by PATH Int'l to be precautions and contraindications for therapeutic riding:

- Degenerative Joint Conditions
- Heart/Cardiac Conditions
- Hip Subluxation and Dislocation
- Indwelling Catheters
- Skin Integrity

GAIT TRC accepts participants into one or more of the programs offered at this facility on an individual basis. Individuals are assessed by GAIT TRC professional staff, or contracted therapists, or recommendations by professionals in the health and educational fields and accepted with parental and/or caregiver consent. Discharge of participants would follow the PATH Accreditation Standards A-11.

We look forward to providing you with our "Premier" Level of service! We hope you have as much fun at GAIT TRC as we do!

Sincerely,

The GAIT Board of Directors, Staff, Instructors, Volunteers, and (of course) the Horses!

PREMIER ACCREDITED CENTER
PATH INTERNATIONAL
Professional Association of Therapeutic Horsemanship International

GAIT THERAPEUTIC RIDING CENTER
PO Box 69 Milford, PA 18337
(Tel) 570-409-1140
(Fax) 570-300-2288
(Email) gaitpa@gmail.com
(Website) www.gaittrc.org

GAIT TRC

Thank you for your interest in GAIT Therapeutic Riding Center (GAIT TRC). If you have any questions regarding this packet please call 570-409-1140 or email us at *gaitpa@gmail.com*

EQUINE ASSISTED LEARNING (EAL) FORMS

These forms must be completed, signed and returned to GAIT TRC two weeks prior to the first session. *These forms are valid for the current year only and must be renewed annually.* Applications for all programs are available via GAIT's website *www.gaittrc.org*.

Enclosed are **six (6)** forms that need your attention and signature:

- Form 1 Application and Contact Information
- Form 2 Release of Information Consent Form
- Form 3 Participant's Health History and Goals
- Form 4 Authorization for Emergency Medical Treatment
- Form 5 Participant's Liability and Photo/Media Release
- Form 6 Participant's Medical Clearance and Physician's Statement

(Form 6 is to be completed & signed by the participant's physician)

I. PAYMENT AND ATTENDANCE

The focus of EAL lessons is to learn horsemanship skills. Skills may include grooming, horse handling, tacking, and riding.

- Each Session consists of one lesson per week for 4 weeks
- Each Session is $260 per participant. Please include payment with these forms
- Please arrive at your scheduled time. Cancelations must be made 24 hours in advance
- There may be a cancellation fee of $30 for missed sessions without 24 hour notice

II. ATTIRE

All participants should come dressed appropriately for outdoor weather conditions and for riding, which should include:

- Riding boots or hard soled shoe with a heel (no open-toed shoes or sandals)
- Long pants
- Helmets (provided by GAIT) must be worn while in the arena, while riding, and while interacting with the horse
- ASTM-SEI (American Society for Testing and Materials – Safety Equipment Institute) helmets are required for each participant
- Safety stirrups will be used on all saddles

I have read and understand the GAIT TRC policies as set forth on this page.

Signature: _____ *Date:* _____

GAIT TRC

Application and Contact Information

(Form 1)

PREMIER ACCREDITED CENTER
PATH INTERNATIONAL
Professional Association of Therapeutic Horsemanship International

PARTICIPANT'S APPLICATION:

Date: _____

Participant's Contact Information

Participant's Name: _____

DOB: _____ Age: _____ Height: _____ Weight: _____

PATH Int'l sets weight limits for horse's safety. Ht. / Wt. is required to determine appropriate horse for rider

Address: _____ City: _____ State: ___ Zip Code: _____

County the Participant Lives In: _____

Telephone#: _____ Cell#: _____

Work#: _____ E-Mail:_____

Preferred Method of Contact: ☐ Home Phone ☐ Cell Phone ☐ Work Phone ☐ Email

For communication purposes, please be sure to notify GAIT of any changes to contact information ASAP

Parent/Legal Guardian/Authorized Caregiver Contact Information

Name: _____

Address: _____ City: _____ State: ___ Zip Code: _____

Telephone#: _____ Cell#: _____

Work#: _____ E-Mail:_____

Emergency Contact Information

Name: _____ Relation: _____ Phone: _____

Name: _____ Relation: _____ Phone: _____

Name: _____ Relation: _____ Phone: _____

GAIT TRC

Release of Information Consent Form

(Form 2)

PREMIER ACCREDITED CENTER
PATH INTERNATIONAL
Professional Association of Therapeutic Horsemanship International

PARTICIPANT'S CONSENT:

I hereby authorize: _____
(physician or health care facility)

to release information from the records of: _____ DOB: _____
(participant's name and date of birth)

to: _____ ***GAIT Therapeutic Riding Center (GAIT TRC)*** _____

for the purpose of developing an equine activity program for the above named participant. The information to be released is indicated below:

- ☐ Medical History
- ☐ Physical Therapy evaluation, assessment and program plan
- ☐ Occupation Therapy evaluation, assessment and program plan
- ☐ Speech Therapy evaluation, assessment and program plan
- ☐ Mental Health diagnosis and treatment plan
- ☐ Individual Habilitation Plan (I.E.P.)
- ☐ Classroom Individual Education Plan (I.E.P.)
- ☐ Psychosocial evaluation, assessment and program plan
- ☐ Cognitive-Behavioral Management Plan
- ☐ Other:_____

This release is valid for one year and can be revoked, in writing, at my request.

☐ I do NOT give my consent/permission to release information given to GAIT Therapeutic Riding Center (GAIT TRC).

Signature: _____ Date: _____

Print Name: _____

Relation to Participant: _____
(Parent/Legal Guardian/Authorized Caregiver)

GAIT TRC

Participant's Health History and Goals

(Form 3)

PREMIER ACCREDITED CENTER
PATH INTERNATIONAL
Professional Association of Therapeutic Horsemanship International

HEALTH HISTORY:

Diagnosis: _____ Date of Onset: _____

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

MEDICATIONS *include prescription, over-the-counter; name, dose and frequency*

_____

_____

_____

_____

Describe your abilities/difficulties in the following areas (include assistance required or equipment needed):

PHYSICAL FUNCTION *i.e. mobility skills such as transfers, walking, wheelchair use, etc.*

_____

_____

_____

_____

PSYCHO/SOCIAL FUNCTION *i.e. Work/school, leisure interests, relationships-family structure, support systems, companion animals, fears/concerns, etc.*

_____

_____

_____

_____

Describe what personal goals or skills you would like to achieve. How can GAIT help you?

GOALS *i.e. socialization, recreation, improve sensory awareness, increase core strength, etc.*

_____

_____

_____

_____

Signature: _____ *Date:* _____

GAIT TRC

Authorization for Emergency Medical Treatment

(Form 4)

PATH INTERNATIONAL
Professional Association of Therapeutic Horsemanship International

AUTHORIZATION:

Name: _____ DOB: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Emergency Contact: _____ Relation: _____ Phone: _____

Physician's Name: _____ Preferred Medical Facility: _____

Health Insurance Company: _____ Policy #: _____

Allergies to medications: _____

Current medications: _____

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 GAIT TRC, I authorize GAIT TRC 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 "lifesaving" by the physician. This provision will only be invoked if the person(s) above is unable to be reached.

Consent Signature: _____ Date:_____

(Client/Parent/Legal Guardian/Authorized Caregiver)

NON-CONSENT PLAN

Parent/Legal Guardian/Authorized Caregiver must remain on site at all times during equine assisted activities.

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 GAIT Therapeutic Riding Center

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

Non-Consent Signature: _____ Date:_____

(Client/Parent/Legal Guardian/Authorized Caregiver)

GAIT TRC

Participant's Liability and Photo/Media Release Form

(Form 5)

RELEASES:

There are 2 separate releases on this form. Please sign and date for each release separately.

1. *LIABILITY RELEASE:*

I would like to participate in GAIT TRC's program. I acknowledge the risks and potential for risks of horseback riding or working with or around horses. However, I feel that the possible benefits to me/my son/my daughter/my ward are greater than the risk assumed. I hereby, intending to be legal bound, for myself, my heirs and assigns, executors or administrators, waive and release forever all claims for damages against GAIT TRC, its Board of Directors, Instructors, Therapists, Aides, Volunteers and/or Staff for any and all injuries and/or losses I/my son/my daughter/my ward may sustain while participating in any GAIT programs.

Signature: _____ *Date:* _____

2. *MEDIA RELEASE:* for all promotional materials including *(but not limited to)* photographs, audio/videos, testimonials for our use on our website or Facebook page and/or for print:

I, _____ (*print name*),

☐ **DO** ☐ **DO NOT** *(check one)*

consent to and authorize the use and reproduction by GAIT TRC of any and all audio/visual materials taken of me/my son/my daughter/my ward for promotional material, education activities, website, or for any other use for the benefit of the program.

Signature: _____ *Date:* _____ _____

GAIT TRC

Participant's Medical Clearance and Physician Statement

(Form 6)

To be completed and *signed* by the Participant's Physician

Participant: _____ DOB: _____

Address: _____City: _____ State: ____ Zip: _____

Diagnosis: _____ Date of Onset: _____

Height: _____ Weight: _____

**PATH Intl. sets weight limits for horse's safety. Ht. / Wt. is required to determine appropriate horse for rider*

Past/Prospective Surgeries: _____

Medications: _____

Seizure Type: _____ Controlled: Y N Date of last Seizure: _____

Shunt Present: Y N Date of last revision: _____

Special precautions/needs: _____

Mobility: Independent Ambulation: Y N Assisted Ambulation: Y N Wheelchair: Y N

Braces/Assistive Devices: _____

Neurological Symptoms of Atlantoaxial Instability: _____ Present _____ Absent

Please indicate current or past special needs in the following systems/areas, including surgeries:

	Y	N	COMMENTS
Auditory			
Visual			
Tactile Sensation			
Speech			
Cardiac			
Circulatory			
Integumentary/Skin			
Immunity			
Pulmonary			
Neurological			
Muscular			
Balance			
Orthopedic			
Allergies			
Learning Disability			
Cognitive			
Emotional/Psychological			
Pain			
Other			

To my knowledge, there is no reason why this person cannot participate in supervised equine activities. However, I understand that the PATH Accredited Center will weigh the medical information above against the existing precautions and contraindications.

Physician Name: _____ MD DO NP PA Other _____

Signature: _____ Date: _____

Address: _____

Phone: _____ License/UPIN Number: _____