



# GAIT Therapeutic Riding Center

Horses Connecting Humans in Mind, Body, & Spirit

## Welcome to GAIT Therapeutic Riding Center!

### GAIT's MISSION:

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

### BOARD OF DIRECTORS

Paul Stefany, *President*  
Ginger Jones, *Treasurer*  
Ruth Ogden, *Secretary*  
Dan Gordon

Martha Dubensky  
*Executive Director*

### ADVISORY BOARD

Jerry Beaver  
Peggy Emanuel  
Elizabeth Erickson-Kameen,  
*Esq*  
Kelly Gaughan, *Esq*  
Kathleen Hendrickson  
Christopher King  
Karen Kontizas  
Patricia Lutfy  
Vera Remes  
Miriam Siegel  
Carolyn Stieh  
Sandy Stalter  
Patricia Walker

GAIT TRC  
PO Box 69  
Milford, PA 18337

Phone: 570-409-1140  
Fax: 570-300-2288  
Email: [gaitpa@gmail.com](mailto:gaitpa@gmail.com)

[www.gaittrc.org](http://www.gaittrc.org)  
[facebook.com/GAIT.TRC](https://facebook.com/GAIT.TRC)

Thank you for your interest in participating in our programs!

GAIT TRC is a 501 (c)(3) non-profit organization and a Premier Accredited Center through PATH, Intl. (*Professional Association of Therapeutic Horsemanship, International*). All equine sessions are conducted by PATH Int'l Certified Instructors, Equine Specialists, licensed therapists, credentialed mental health professionals, and highly trained volunteers.

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

- Degenerative Joint Conditions
- Heart/Cardiac Conditions
- Atlantoaxial Instability (AAI)
- Indwelling Catheters
- Skin Integrity
- Spinal Stenosis

GAIT TRC accepts participants into one or more of the programs offered at this facility on an individual basis. Individuals are assessed by GAIT's professional staff, 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,

GAIT's Board of Directors, Staff, Volunteers, and Horses!





## GAIT THERAPEUTIC RIDING CENTER

PO Box 69 Milford, PA 18337  
(Phone) 570-409-1140 (Fax) 570-300-2288  
(Email) gaitpa@gmail.com (Web) www.gaittrc.org



---

## Therapeutic Riding (TR) Forms

Please complete and sign all **six (6)** enclosed forms and return to GAIT TRC two weeks prior to the first class. **These forms are valid for the current year only, and must be updated each year.** Event calendars, program applications, and scholarship information is available via GAIT's website [www.gaittrc.org](http://www.gaittrc.org).

---

### POLICIES OF GAIT TRC

In order to provide the safest conditions possible and quality services, we ask that all participants and their families adhere to our policies. Please review the following policies for GAIT TRC and sign all necessary forms. If you have any questions regarding this packet, please contact our office.

#### I. Payment and Attendance

Please arrive on time for your scheduled class. If you are unable to keep your appointment, please email or call ahead so we can make proper arrangements for our horses and staff/ volunteers.

- Each Session consists of one class per week for 7 weeks
- Cost for each session is \$315 per participant. Please include payment prior to each new session
- GAIT TRC does NOT give refunds or make up for missed classes
- GAIT TRC will remain open during holidays and classes will continue as scheduled. In the event of bad weather, classes will resume inside the indoor arena. Cancellations will only be made in the event of an emergency

#### II. Safety Guidelines

- No smoking ANYWHERE on the premises
- Parents/ legal guardians/ authorized caregivers are responsible for the supervision of participants and non-participants while at GAIT and must remain on the premises
- 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 a safe ride
- **To ensure the longevity of our horses, all mounted activities are limited to 180 lbs. weight limit**
- A physician must sign and date **Form 6 (Medical Clearance)** and include participant's height/ weight. We are unable to allow participation without an annual clearance from a physician

#### III. Attire

- Dress appropriately for outdoor weather conditions and riding
- Please wear riding boots or hard soled shoe with a heel (*no open toed shoes or sandals*)
- Please wear long pants and t-shirts to protect skin while riding
- ASTM-SEI (*American Society for Testing and Materials – Safety Equipment Institute*) helmets are required for each participant. Helmets (*available at GAIT*) must be worn while in the arena, while riding, and while interacting with the horse
- Safety stirrups will be used on all saddles



# Participant Application and Contact Information (Form 1)



**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: \_\_\_\_\_

*Your thoughts mean the world to us- please consider providing GAIT a testimonial about your experience. How has this program made an impact for you or your child?  
How may we help you to achieve your goals in the future?*

*Your feedback will help us request grants, spread the word about GAIT, and help us to continue providing the best services possible for our participants. Please attach your testimonial with this application, or email [gaitpa@gmail.com](mailto:gaitpa@gmail.com)*



# Release of Information Consent Form (Form 2)



## **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)



# Participant's Health History and Goals (Form 3)



## **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*

---

---

---

---

---

**PHYSICAL FUNCTION:** Describe your abilities/difficulties in the following areas. Please include assistance required or equipment needed (*i.e. mobility skills such as transfers, walking, range of motion, wheelchair use, etc.*)

---

---

---

---

---

**PSYCHO/SOCIAL FUNCTION:** *i.e. Work/school, favorite music, color, activities, etc., family structure, support systems, companion animals, fears/concerns, etc.*

---

---

---

---

---

**GOALS:** Describe what personal goals or skills you would like to achieve. How can GAIT help you? *i.e. socialization, recreation, improve sensory awareness, increase core strength, etc.*

---

---

---

---

---



# Authorization for Emergency Medical Treatment

(Form 4)



## **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)



# 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:** \_\_\_\_\_



# Participant's Medical Clearance and Physician Statement

(Form 6)

To be completed and signed by a 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, Intl. 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: \_\_\_\_\_