GAIT Therapeutic Riding Center

Horses Connecting Humans in Mind, Body, & Spirit

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.

GAIT TRC
PO Box 69
Milford, PA 18337

Phone: 570-409-1140
Fax: 570-300-2288
Email: gaitpa@gmail.com

www.gaittrc.org
facebook.com/GAIT.TRC

Welcome to GAIT Therapeutic Riding Center!

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 partial 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

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(Email) gaitpa@gmail.com (Web) www.gaittrc.org

Hippotherapy (HPOT) Forms

Please complete and sign all **four (4)** enclosed forms and return to GAIT TRC two weeks prior to the first session. 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*.

POLICIES OF GAIT TRC

The physical, occupational, and speech therapists who conduct sessions at GAIT TRC are all licensed in Pennsylvania and are PATH registered therapists in Hippotherapy.

- For Hippotherapy with a Physical Therapist - a prescription from a physician is required *(not required for HPOT with an Occupational Therapist or Speech/ Language Pathologist)*
- 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
- Each therapist will evaluate the rider either before or during the first Hippotherapy session to formulate a plan and goals. There may be an additional fee for this evaluation

I. Payment and Attendance

Sessions are scheduled by the therapist and arranged through GAIT TRC. If you cannot attend the scheduled session, a call to the therapist or to GAIT TRC to cancel **MUST BE** made at least 24 hours prior to your scheduled time. A cancellation fee of $30.00 will be charged for missed sessions without 24 hours' notice in advance.

For **½ hour session** for the rider with a one-on-one session with a therapist:

Therapist (only for sessions he/she conducts)	$40.00
GAIT TRC	$25.00
TOTAL	**$65.00**

For **1 hour session** as above, the fee is:

Therapist (only for sessions he/she conducts)	$80.00
GAIT TRC	$50.00
TOTAL	**$130.00**

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
- 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

Signature: _____ *Date:* _____

GAIT TRC

Participant Application and Contact Information

(Form 1)

PATH INTERNATIONAL
Professional Association of Therapeutic Horsemanship International
PREMIER ACCREDITED CENTER

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

GAIT is going paperless! Please provide a current email address to receive invoices and important notifications.

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

GAIT TRC

Authorization for Emergency Medical Treatment

(Form 4)

PATH INTERNATIONAL
Professional Association of Therapeutic Horsemanship International
PREMIER ACCREDITED CENTER

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

Liability and Photo/Media Release Form

(Form 5)

PATH INTERNATIONAL
Professional Association of Therapeutic Horsemanship International
PREMIER ACCREDITED CENTER

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 a Physician

PATH INTERNATIONAL
Professional Association of Therapeutic Horsemanship International
PREMIER ACCREDITED CENTER

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: _____