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.

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GAIT TRC
PO Box 69
Milford, PA 18337

Phone: 570-409-1140
Fax: 570-300-2288
Email: info@gaittrc.org

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 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-9.

NEW POLICY AT GAIT TRC 2020

- To become more uniform in GAIT TRC classes, the Board of Directors is requesting that all programs will be in 7 week increments *(see calendar for Session dates on website),* with the 8th week being free for horses and volunteers.
- Billing will be more uniform for participants and our business office. This time will also allow horses to re-group and "be horses" again.
- All programs will run as is, with no increase in service costs for 2020; fees will be based on 7 week sessions.

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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Equine Assisted Learning (EAL) Forms

Please complete and sign the 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.

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 you appointment, please email or call ahead so we can make proper arrangements for our horses and staff/ volunteers.

- Each Session consists of one lesson per week for 7 weeks
- Cost for each session is $525 per participant. Please include payment prior to each new session
- Cancelations must be made 24 hours in advance. There may be a cancellation fee of $30 for missed sessions without 24 hour notice
- 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. Cancelations will only be made in the event of an emergency. If you are unsure, or are unable to make your scheduled time, please call the office: 570-409-1140

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 loud noises, using umbrellas, running, or throwing objects while horses are in the arena, as this may distract horses from giving a safe ride
- For your safety, please refrain from climbing/ sitting on fences or gates
- To ensure the longevity of our horses, mounted activities have weight limits
- 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 used in therapeutic riding classes

GAIT TRC

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

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: __________________

GAIT TRC would love to showcase your success stories on our website- please consider providing a testimonial about you and/or your child's experience here. What challenges were you facing before taking lessons? What makes GAIT's programs different? What is life like now that you are reaching your goals/ overcoming challenges? Which horse is your favorite, and why?

Send us a picture of you and your horse doing your thing! Your success makes what we do rewarding! Please let us know if you have any questions about submitting a testimonial.

GAIT TRC

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.*

____

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____

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:* _____ _____

GAIT TRC

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: ________________