



# GAIT Therapeutic Riding Center

GAIT TRC's mission is to improve the quality of life of children & adults with special needs through equine assisted services, resulting in a more independent life in society.

PO Box 69 Milford, PA 18337 Phone: 570-409-1140 Email: [info@gaittrc.org](mailto:info@gaittrc.org) Website: [www.gaittrc.org](http://www.gaittrc.org)

## 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 Int'l (*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 specially 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/caregiver consent. Discharge of participants would follow the PATH Accreditation Standards A-9.

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 (Email) info@gaittrc.org  
(Web) [www.gaittrc.org](http://www.gaittrc.org)



# Hippotherapy (HPOT) Forms

In order to provide the safest conditions possible and quality services, we ask that all participants and their families adhere to GAIT's policies. Please complete and sign the enclosed forms and return prior to the first session. **These forms are valid for the current year only, and must be updated each year.** If you have any questions regarding this packet, please contact our office.

## POLICIES OF GAIT TRC

Any therapist who conducts sessions at GAIT TRC must be licensed in Pennsylvania and be a PATH Intl. Registered Therapist or a Hippotherapy Clinical Specialist (HPCS) in order to provide services.

### I. Payment and Attendance

- The therapist will evaluate the rider either before or during the first session to formulate treatment strategies and goals. There may be an additional fee for this evaluation
- Sessions are scheduled by the therapist and arranged through GAIT TRC. If you cannot attend the scheduled session, cancellations **MUST BE** made at least 24 hours prior to your scheduled time.
- **There will be a cancellation fee of \$45.00 for missed sessions without 24 hours' notice in advance.**
- Active Duty Military, Veterans, first responders, and family members may be eligible to receive funding and/or discount. Please inquire with GAIT's office staff to learn more

For **1/2 hour session** for the rider with a one-on-one session with a therapist:

Therapist	\$40.00
<u>GAIT TRC</u>	<u>\$30.00</u>
<b>TOTAL</b>	<b>\$70.00</b>

### 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 climbing/ sitting on fences or gates, making loud noises, using umbrellas, running, or throwing objects while horses are in the arena, as this may distract horses
- To ensure the longevity of our horses, mounted activities have weight limits
- **A physician must sign and date Form 4 (Medical Clearance) and include participant's height/weight. We are unable to allow participation in riding activities without an annual clearance from a physician**
- Please note that barn environments are unique and may not be possible to fully disinfect every item or equipment
- No open toed shoes or sandals. Please wear boots (*no steel toe*) or sneakers. Riding boots or hard soled shoe with a heel are preferred
- Wear long pants and t-shirts to protect skin; dress appropriately for weather
- ASTM-SEI (*American Society for Testing and Materials - Safety Equipment Institute*) certified helmets are required for each participant while in the arena and/or interacting with the horse. GAIT has ASTM-SEI helmets available for shared use for participants who do not have their own

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

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



# 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**

Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ County: \_\_\_\_\_

Phone: (Home) \_\_\_\_\_ (Cell) \_\_\_\_\_ Email: \_\_\_\_\_

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

Primary Phone: \_\_\_\_\_ Alternate Phone: \_\_\_\_\_

## Emergency Contact Information:

Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Phone: \_\_\_\_\_

We would love to showcase your stories on our website and communications with donors/grantors! Please consider providing a testimonial about your experience at GAIT.

What were some goals that you wanted to achieve, or challenges you wanted to overcome? What do you like about coming to GAIT? Who is your favorite horse, 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.



# Authorization for Emergency Medical Treatment

(Form 2)



## **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 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 3)



## RELEASES:

There are 2 separate releases on this form. Please print name/sign and date each section

### 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 4)

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: \_\_\_\_\_