PO Box 69 Milford, PA 18337 **Phone:** 570-409-1140 **Email:** info@gaittrc.org **Website:** www.gaittrc.org

Welcome to GAIT Equine Assisted Services!

Thank you for your interest in participating in our programs!

GAIT EAS 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 Intl. 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 Intl. 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 EAS 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 Intl. 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 EAS as we do!

Sincerely,

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

GAIT EQUINE ASSISTED SERVICES

PO Box 69 Milford, PA 18337

(Phone) 570-409-1140 (Email) info@gaittrc.org

(Web) www.gaittrc.org

Therapeutic Riding (TR) 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 EAS

I. Payment and Attendance

- Riding classes are 30 min per week
- Cost per participant is $200 for 4 week sessions (winter and fall only) or $350 for 7 weeks. Please include payment prior to each new session
- 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
- GAIT EAS does NOT give refunds or make up for missed classes
- Please arrive/ depart at your scheduled time, allowing time for helmet fitting and/or bathroom visit
- Accessible parking is available next to the barn and indoor arena
- GAIT is open year round with an indoor arena available during inclement weather. Please contact the office if you are unsure of the schedule

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
- Please note that barn environments are unique and may not be possible to fully disinfect every item or equipment
- **A physician must sign and date Form 5 *(Medical Clearance)*** and include participant's height/ weight. We are unable to allow participation in riding activities without clearance from a physician
- Please wear boots *(no steel toe)* or sneakers; riding boots or hard soled shoe with a heel are preferred. Open toed shoes, sandals, or crocs are not permitted.
- 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 Intl. 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

Please provide a current email address *to receive info on schedules, events, and other 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.

Participant's Health History and Goals

(Form 2)

***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 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 3)

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 EAS, 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 Equine Assisted Services

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 4)

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 EAS'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 EAS, 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 EAS 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 5)

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: ____________________