GAIT Equine Assisted Services

GAIT'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 **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 Therapeutic Riding Instructors, PATH Intl. 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 equine 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.

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

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 EAS

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

I. Payment and Attendance

- Fee for each participant is $70 per 30 min session one-on-one with a therapist
- The therapist will evaluate the participant 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 EAS. 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
- GAIT is open year-round with an indoor arena available during inclement weather. **Please contact the office if you are unable to make your appointment so staff can make necessary arrangements with the therapist and horses**

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
- 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)

Participant's Contact Information:

Date: _____

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

For communication purposes, please be sure to notify GAIT of any changes to contact information ASAP

Would like your email to be added to GAIT's newsletter?: **☐ Yes ☐ No**

("NO"- you will only receive emails in regards to billing, program updates, and session calendars. You will not receive emails about GAIT's newsletter, events, or fundraisers. You can opt in or out at any time)

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: _____

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 GAIT's and PATH Intl.'s website, social media sites, and/or for print*:

I, _____ (*print name*),

(check one) ☐ **DO** or ☐ **DO NOT**

hereby consent to and authorize the use and reproduction by GAIT EAS and PATH Intl. of any and all audio/visual materials taken of me/my son/my daughter/my ward for promotional printed materials, website, social media sites, education activities and exhibitions or for any other use for the benefit of GAIT EAS, PATH Intl., and equine-assisted services.

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: _____