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FORMS AND POLICIES HIPPO THERAPY

Call Gigi Kratzke at (570) 409-1140 if you have any questions regarding this packet or email us: gaitpa@gmail.com.

FORMS

Enclosed are **four (4)** forms with each application that need your attention and signature.

- Form 1: Participant's Application and Contact Information
- Form 3: Authorization for Emergency Medical Treatment
- Form 5: Participant's Liability Release and Photo/Media Release
- Form 6: Participant's Medical History and Physician Statement

POLICY FOR NEW AND RETURNING RIDERS

Applications and Forms must be completed, signed and returned to GAIT TRC two weeks prior to the first class. **These forms are valid for the current year only.** You will need to fill out all forms for the application every year.

Riders (or guardians) must complete the GAIT TRC's paperwork as well as receive a prescription from their physician for Hippotherapy with a Physical Therapist. (This is not required for Hippotherapy with an Occupational Therapist or a Speech Language Pathologist). 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.

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

PAYMENT AND ATTENDANCE POLICY FOR HIPPO THERAPY

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! GAIT TRC phone number is: 570-409-1140. Please leave a message if it is after hours.**

It is the policy of GAIT TRC – As set by the Board of Directors – that if a participant scheduled for a Hippotherapy Lesson does not call GAIT TRC at least 24 hours in advance – payment for that lesson will still be required.

Payment for Hippotherapy Sessions at GAIT TRC are as follows:

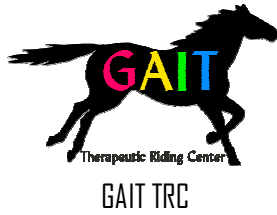
For ½ hour session for the rider with a one-on-one session with a therapist:

Therapist	\$30.00
GAIT TRC	\$20.00
TOTAL	\$50.00

For 1 hour session as above, the fee is:

Therapist	\$60.00
GAIT TRC	\$40.00
TOTAL	\$100.00

I read and understand the GAIT TRC policies as set forth on this page. _____
(Signature)



Participant's
Application and
Contact Information
Hippotherapy
(Form 1)



HIPPOTHERAPY APPLICATION:

Today's Date: _____

(Participant Information)

Participant's Name: _____ DOB: _____ AGE: _____ HT: _____ Weight: _____

Address: _____ City: _____ State: _____ Zip Code: _____

County the Participant Lives In: _____

Telephone#: _____

Cell#: _____

Work#: _____

E-Mail: _____

(Since most communication will be primarily via email, please make sure we have a current, valid email address!)

(Parent/Guardian Contact Information)

Parent/Guardian Name: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Telephone#: _____

Cell#: _____

Work#: _____

E-Mail: _____

(School/Institution Contact Information)

School/Institution presently attending: _____

Contact Person: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Telephone#: _____

Cell#: _____

Work#: _____

E-Mail: _____



Authorization for Emergency Medical Treatment

(Form 3)



Name: _____ DOB: _____ Phone: _____
Address: _____ City: _____ State: _____ Zip: _____
Physician's Name: _____ Preferred Medical Facility: _____
Health Insurance Company: _____ Policy #: _____
Allergies to medications: _____
Current medications: _____

IN THE EVENT OF AN EMERGENCY, CONTACT:

Name: _____ Relation: _____ Phone: _____
Name: _____ Relation: _____ Phone: _____
Name: _____ Relation: _____ Phone: _____

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 "life saving" by the physician. This provision will only be invoked if the person(s) above is unable to be reached.

Consent Signature: _____ Date: _____
(Client, parent or legal guardian)

NON-CONSENT PLAN

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 TRC.

Parent or legal guardian must remain on site at all times during equine assisted activities. In the event emergency treatment/aid is required, I wish the following procedure to take place:

Non-Consent Signature: _____ Date: _____
(Client, parent or legal guardian)



Participant's Releases (Form 5)



RELEASES:

There are 2 separate releases on this form. Each release must be signed separately. Hence, there should be 2 signatures on this page.

1. LIABILITY RELEASE:

_____ (client's name) would like to participate in GAIT'S program. I acknowledge the risks and potential for risks of horseback riding. However, I feel that the possible benefits to my self/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 TRC programs.

Signature: _____ **Date:** _____

2. MEDIA RELEASE for all promotional materials including (but not limited to) photographs, audio/videos, testimonials for website or for print:

- DO
- DO NOT

I 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 History and Physician Statement

(Form 6)

To be completed and *signed* by the
Participant's Physician)



Participant: _____ AGE: _____ DOB: _____

Height: _____ Weight: _____

Address: _____ City: _____ State: _____ Zip: _____

Diagnosis: _____ Date of Onset: _____

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: _____

For those with Down Syndrome: AtlantoDens Interval X-rays, Date: _____ Result + -

Neurological Symptoms of AtlantoAxial Instability: _____

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 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: _____