

**G.A.I.T. INC.  
THERAPEUTIC  
RIDING  
CENTER**

[www.gaitpa.org](http://www.gaitpa.org)

**BOARD OF DIRECTORS**

*Missi Strub  
President*

*Carolyn Stieh  
Secretary*

*Miriam Siegel  
Treasurer*

*Kathleen Hendrickson  
Grant Writer*

*Tom O'Hara  
Member*

*Deborah Fischer  
Member*

*Sandy Stalter  
Member*

*Martha Dubensky  
Executive Director*

**G.A.I.T.**  
PO Box 69  
Milford, PA 18337  
570-409-1140 (phone)  
570-409-1078 (fax)  
[gaitpa@gmail.com](mailto:gaitpa@gmail.com) (email)



**Welcome to G.A.I.T. !**

Enclosed you will find a packet of information regarding G.A.I.T. Therapeutic Riding Center. You can learn even more about G.A.I.T. by going to G.A.I.T.'s official website: [www.gaitpa.org](http://www.gaitpa.org).

Starting in 2009, we will be putting our quarterly newsletters on the website as well. Our newsletters contain a lot of important information about upcoming special events and program schedules. The newsletter also contains information about G.A.I.T.'s sponsors. Additionally, the newsletter contains fun facts regarding our most treasured resource--our horses!

The forms and releases sent with this package can also be found on our website by clicking on the "downloads" link on the menu on the left-hand side of the webpage.

**Important Note:**

*These forms must be completed, signed, dated and returned to G.A.I.T. before the rider's first riding class or the rider will not be allowed on the horse! If you lose these forms, you can always download them from the G.A.I.T. website. These forms are good for the current year only and must be renewed (completed, signed, dated and returned to G.A.I.T.) each and every year.*

G.A.I.T. Inc. is a non-profit organization. Typically, riders pay a class fee that is about 50% of the actual cost of running our programs. G.A.I.T. relies on private donations, memberships, fund-raisers, and grants to make up the difference in operational costs.

G.A.I.T. is a *Premier Accredited Center through NARHA*, the international accreditation organization for the therapeutic riding industry. NARHA establishes accreditations and certifications for safety and instructional standards for therapeutic riding centers.

G.A.I.T. currently has two NARHA-Certified Registered Instructors and one NARHA *Advanced Certified Instructor*. She is also the Executive Director and Founder of G.A.I.T., Ms. Martha Dubensky.

**Policies of G.A.I.T.**

1. No Smoking ANYWHERE on the premises.
2. Everyone is welcome at G.A.I.T., but we are primarily concerned with the safety and instruction of the riders, and the safety of our volunteers, guests and horses, therefore, siblings CANNOT participate in any ground or riding activities and the people who bring them MUST take full responsibility for watching them.
3. Please refrain from using umbrellas while horses are in the arena. Also, loud noises such as shouting, clapping or door banging may distract the horses from giving your child a safe ride.
4. Other policies are available upon request.

*Continued on page 2.....*

**G.A.I.T. INC.  
THERAPEUTIC  
RIDING  
CENTER**

[www.gaitpa.org](http://www.gaitpa.org)

**BOARD OF DIRECTORS**

*Missi Strub  
President*

*Carolyn Stieh  
Secretary*

*Miriam Siegel  
Treasurer*

*Kathleen Hendrickson  
Grant Writer*

*Tom O'Hara  
Member*

*Deborah Fischer  
Member*

*Sandy Stalter  
Member*

*Martha Dubensky  
Executive Director*

**G.A.I.T.**  
PO Box 69  
Milford, PA 18337  
570-409-1140 (phone)  
570-409-1078 (fax)  
[gaitpa@gmail.com](mailto:gaitpa@gmail.com) (email)



**Welcome to G.A.I.T. !**

*Continued from page 1.....*

The following is a partial list of diagnoses of conditions, syndromes, disorders and problems as assessed by NARHA to be precautions and contraindications for therapeutic riding:

- ADHD/Attention Deficit Disorder
- ASD/Pervasive Developmental Disorders
- Asthma
- Behavior and Psychosocial Problems
- Cerebral Palsy
- Head/Neck Control
- Myopathy/Muscular Dystrophy
- Neuromuscular Disorder/Multiple Sclerosis (MS)
- Seizure Disorders/Epilepsy
- Traumatic Brain Injury

Please be sure your physician is aware of your rider's particular diagnoses for precautions and contraindications whether it is shown on the above partial list or not. *If you have any questions regarding this, ask your physician.* G.A.I.T. requires all riders to be seen and examined by their personal physician each and every year BEFORE their first therapeutic riding class for that year. The physician must sign FORM 6 (Physician's Statement) and you are required to give it to G.A.I.T. staff before the participant's first therapeutic riding class.

G.A.I.T. Therapeutic Riding Center accepts participants into one or more of the programs offered at this facility on an individual basis. Individuals are assessed by G.A.I.T. professional staff, or contracted therapists, or recommendations by professionals in the health and educational fields and accepted with parental and/or caregiver consent.

We look forward to providing you with our "Premier" Level of service! We hope you have as much fun at G.A.I.T. as we do!

Sincerely,  
The G.A.I.T. Board of Directors, Staff, Instructors, Volunteers, and (of course) the Horses!

**G.A.I.T., INC.  
NARHA  
PREMIER ACCREDITED  
PROGRAM**



**P.O. BOX 69  
Milford, PA 18337  
570-409-1140 (Tel)  
570-409-1078 (Fax)  
[gaitpa@gmail.com](mailto:gaitpa@gmail.com) (Email)  
[www.gaitpa.org](http://www.gaitpa.org) (Website)**

---

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

## **Forms**

All Six (6) Forms must be completed, signed and returned to G.A.I.T. two weeks prior to the first class of the session. ***These forms are valid for the current year only!***

Enclosed are six (6) forms that need your attention and signature:

- Form 1 Participant's Application and Contact Information
- Form 2 Participant's Consent for Release of Information
- Form 3 Authorization for Emergency Medical Treatment
- Form 4 Participant's Health History
- Form 5 Participant's Liability Release and Photo Release
- Form 6 Participant's Medical History and Physician Statement

***(Form 6 is to be completed & signed by the participant's physician)***

## **Payment**

Each Session consists of one class per week for 7 weeks.

Each class is one hour long.

Payment should be included with these forms.

- Each Session is \$245 per participant.
- G.A.I.T. does NOT give refunds for classes that are missed during a Session.

## **Attire**

All participants should come dressed appropriately for riding, which should include:

- Riding boots or hard soled shoe with a heel.
- Long pants.
- American Society for Testing and Materials – Safety Equipment Institute (ASTM-SEI) Helmets are provided for each rider and must be worn while in the arena and while riding.
- Safety stirrups will be used on all saddles.

Thank you for your interest in the G.A.I.T. Therapeutic Riding Center.

*G.A.I.T. is a Federal 501(c)(3) non-profit, charitable organization (EIN 22-3444872) for the benefit of special needs persons in Pennsylvania, New York, and New Jersey.*



# Participant's Application and Contact Information

(Form 1)



## **APPLICATION: (Participant Information)**

Participant's Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_

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!)*

Which Program(s) is the Participant Interested in Applying For? (Circle Below)

Therapeutic Riding

Equine Assisted Learning

Equine Assisted Psychotherapy

Vocational Training

Other (Explain) \_\_\_\_\_

## **(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: \_\_\_\_\_



# Participant's Consent for Release of Information (Form 2)



I hereby authorize: \_\_\_\_\_  
(agency, facility, professional, school, etc.)

to release information from the records of: \_\_\_\_\_ DOB: \_\_\_\_\_  
(potential rider name)

The information is to be released to: **G.A.I.T. Therapeutic Riding Center**  
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

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name: \_\_\_\_\_

Relation to Participant: \_\_\_\_\_

Please send materials to:

G.A.I.T. Inc.  
PO Box 69  
Milford, PA 18337  
Attn: Gigi Kratzke



# 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 G.A.I.T., I authorize G.A.I.T. 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 G.A.I.T.

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 Health History

(Form 4)



## **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)*

---

---

---

*Describe your abilities/difficulties in the following areas (include assistance required or equipment needed):*  
PHYSICAL FUNCTION (i.e. mobility skills such as transfers, walking, wheelchair use, driving/bus riding)

---

---

---

PSYCHO/SOCIAL FUNCTION (i.e. Work/school including grade completed, leisure interests, relationships- family structure, support systems, companion animals, fears/concerns, etc.)

---

---

---

## **GOALS**

(Why are you applying for participation? What would you like to accomplish?)

---

---

---

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



# 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 G.A.IT.'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 G.A.I.T., 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 G.A.I.T. programs.

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

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

- DO
- DO NOT

I consent to and authorize the use and reproduction by G.A.I.T. 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: \_\_\_\_\_ 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 NARHA 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: \_\_\_\_\_