



**Faith Equestrian Therapeutic Center**  
**(912) 728-3728 / (912) 655-1480**

### **Introduction and Cover Letter**

Thank you for your interest in Faith Equestrian Therapeutic Center (FETC). The first step toward participating in a FETC program is to complete and return the necessary forms.

Before a participant can be considered for inclusion in the Faith Equestrian Therapeutic Center programs the attached forms must be completed and returned to FETC.

- > New and present participants must meet the FETC age and weight policy as stated on attached "Policies" sheet (keep the policies for your records)
- > Physician's cover letter and medical history & physician's statement must be completely filled out, dated and signed by the participant's physician within the last 6 months, these need renewed every 2 years (Exception: Participants with Down syndrome, a physical must be done yearly)
- > Participant's Authorization for Emergency Medical Treatment needs to be completed
- > Participant's registration and photo release forms completed
- > Risk waiver / release signed by parent or guardian

Once all forms are received at Faith Equestrian Therapeutic Center and are verified for completeness, and we are notified of acceptance in an assistance program, refused, or haven't applied, an evaluation will be arranged. During the evaluation, we will ensure that our program is appropriate for the potential participant and that there are no contraindications to participation in horseback riding activities. We will also discuss other assistance sponsorships (if you have been refused assistance or have not applied) A brief mounted evaluation will take place if appropriate. Spaces are reserved on a first come first serve basis.

FETC strives to provide the safest possible conditions for participants, volunteers, employees and horses. The acceptance and continued participation of a participant in our program depends on the availability of instructors, volunteers and suitable horses, and is based on our determination that we can safely accommodate the participant. FETC adheres to precautions and contraindications for participants established by the Professional Association of Therapeutic Horsemanship Intl (PATH). FETC retains the right to refuse any participant that we cannot safely accommodate. Participants must inform FETC of changes in their health status and an annual update form is required.

FETC offers classes Monday through Saturday, year round on a session basis. The length of session will be based on the time of year the session is running.

Tuition cost-\$35 per class, which must be paid by parent/guardian or absorbed by special assistance, sponsorships or scholarships. Please check the calendar for current session length. Most sessions are either 10 weeks (\$350 for session) or 7 weeks long (\$245 per session). It is recommended that you apply for assistance as part of the application process, but remember, we will help you find assistance or sponsorships if you are refused by an assistance program that you apply to, and we will help you fill out all forms if needed.

We thank you for your interest and look forward to serving you soon. Please feel free to contact the office if you have any questions at (912)-728-3728 or (912)-655-1480 Monday through Friday 9am -5pm or Saturday 9am-3pm.

Sincerely,

**Bonnie Rachael / CEO**



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**Policies**

Unfortunately, riding is not an appropriate activity for everybody and we occasionally have to decline or discontinue services to those to whom riding is contraindicated or inappropriate. As a PATH (Professional Association of Therapeutic Horsemanship, Intl.) program we follow the PATH guidelines in all activities at FETC.

**Eligibility**

**Age Policy**

The minimum age is 4 years old for therapeutic riding lessons, there is no maximum age limit as long as the person can meet the below criteria.

**Weight Policy**

Therapeutic riding may be considered contraindicated if:

1. The volunteers are unable to safely manage the participant in any situation, including an emergency dismount.
2. The safety of the horse is compromised during any mounted activities.
3. The participant does not fall below the maximum weight limit which is 175 lbs. Some exceptions will be made on an individual basis by the instructor; some factors that may determine this are the cognitive skills, balance, mobility, etc. of the rider.

**Ineligibility**

Each applying participant will be assessed by an instructor to determine whether they qualify for therapeutic riding. Based on the following criteria an instructor has the right to disapprove an applicant:

1. Does not meet the above weight and/or age criteria.
2. After assessing other factors such as cognitive skills and balance, the instructor may believe that riding is contraindicated.
3. If a doctor advises against riding.
4. If the applicant falls under the PATH list of contraindications.
5. If the instructor believes the applicant will not benefit from therapeutic riding or that they are capable of typical riding lessons.

**Discharge of Participants**

If, at any point in the participant's active enrollment at FETC, the instructor believes that therapeutic riding is no longer applicable to the participant, the instructor has the right to discharge the participant. The following are some of the factors that may lead to being considered ineligible:

1. Participant no longer meets the weight limit.
2. Participant no longer benefits from therapeutic riding lessons.
3. The participant's doctor advises against riding
4. The participant has been absent 3 times without notice (see absence policy below).
5. If the participant has not paid the tuition for the session, they will not be able to ride until it is paid.
6. If the instructor believes the safety of the participant, horse, or volunteers is at risk.



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### Absence Policy

Classes are held weather-permitting, if it is raining or rain is imminent, or if the day time temperature is extreme heat or extreme cold, classes will be continued the following week. If a participant is absent, there is no make-up class, make-up classes are scheduled only when FETC cancels for non-weather related reasons. Because a number of volunteers commit their time to ensure a safe ride, we request 24 hours notice when a participant knows they will be absent.

### Confidentiality Policy

I understand that information about the participant will remain confidential unless the appropriate release of information form is signed. Without this form, the participant's information (Name, goals, progress notes, etc.) will not be released, unless it does not include the participant's name. Such information may be used to obtain grants or for research purposes. Our volunteers are asked to sign a confidentiality policy regarding participants and what happens in lessons and by signing this form, I also agree to keep information about the other riders confidential and encourage the participant to do the same.

***By signing below, you acknowledge that you have read and understand all policies in regards to the eligibility and discharge of participants.***

Participant Name \_\_\_\_\_

Participant Signature \_\_\_\_\_

Date \_\_\_\_\_

Or

Parent/ Guardian Signature \_\_\_\_\_

Date \_\_\_\_\_

(If participant is under 18)



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**Authorization of Emergency Medical Treatment Form**

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 the agency, I authorize Faith Equestrian Therapeutic Center to Secure and retain medical treatment and transportation if needed and release client records upon request to the authorized individual or agency involved in the medical emergency treatment.

Participant Name:	Phone:	Phone:
Address:	City:	State / Zip:
if I cannot be reached Contact:	Phone:	Phone:
Alternate Emergency Contact:	Phone:	Phone:
Physician's Name:	Phone:	
Preferred Medical Facility:		
Health Insurance Company:	Policy*:	

<b>Consent Plan</b>	
The 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 below is unable to be reached.	
Consent Signature: (Client, Parent or Guardian):	Date:
Please Print Name:	Phone*:

<b>Non-Consent Plan</b>	
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 the agency. In the event emergency treatment/aid is required, I wish the following procedures to take place:	
_____	
_____	
_____	
Consent Signature: (Client, Parent or Guardian):	Date:
Please Print Name:	Phone*:



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**Client Medical History & Physicians' Statement**

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Participant Name:	Date of Birth:	Age:	Sex:	Race:	Height:	Weight:
Name / Address of Guardian:				Tetanus Shot:	YES	NO
Diagnosis:				Date:	Date of Onset:	
Medications:						

Please indicate if patient has a problem and/or surgical history in any of the following areas:

AREA	YES	NO	COMMENTS	AREA	YES	NO	COMMENTS
Auditory				Muscular			
Visual				Independent Ambulation			
Speech				Crutches			
Allergies				Braces			
Cardiac				Wheelchair			
Circulatory				Neurological			
Learning Disability				Orthopedic			
Mental				Pulmonary			
Psychological Impairment				Other			
Seizures			Type:	Controlled:			Date of Last Seizure:

\*\* Please complete required information on page 2 for SEIZURE patients \*\* See Page 2 for list of precautions and

**\*Physician Must Sign and Date this Form Below\***

*To my knowledge, there is no reason why this person cannot participate in supervised equine activities. However, I understand that Faith Equestrian will weigh the medical information above against the existing precautions and contraindications. Therefore I refer this person to Faith Equestrian for ongoing evaluation to determine eligibility for participation. I have read the attached precautions and contraindications (page 7).*

Physician's Signature:	Date of EXAM:
Physician's Name (please print):	Physician's Phone:
Address:	Physician's FAX:

**If participant has Down Syndrome or a history of seizures please continue onto next Page 2.**



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**Physician Statement Continued**

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**\*Participants with Down syndrome**

Does the individual have an annual medical clearance from a licensed physician that includes a neurological exam that specifically denies any symptoms consistent with atlanto-axial instability?

Yes No

Has there been a neurological exam that specifically denies any symptoms consistent with atlanto-axial instability (AAI) in the last year?

By signing below I confirm that the participant has revealed no signs of AAI or decrease in neurological function. To my knowledge there is no reason why this person cannot participate in supervised equestrian activities:

Physician's Signature:	Date of EXAM:
Physician's Name (please print):	Physician's Phone:
Address:	Physician's FAX:

**\*Participants with Seizure Disorders**

PATH (Professional Association of Therapeutic Horsemanship Intl) recommends the following information for PATH operating Centers for riders with seizure disorders.

Would you consider \_\_\_\_\_'s seizures to be:

Completely controlled     Very well controlled     Fairly controlled by medication

Type of seizure:	
Typical motor activity during seizure:	
Description of clients behavior during seizure state:	
Specific directions as to what to do if a seizure should occur at Faith Equestrian Therapeutic Center:	
Physicians signature	Date:



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## INFORMATION FOR PHYSICIAN

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The following conditions, if present, may represent precautions or contraindications to therapeutic horseback riding. Therefore, when completing this form, please note whether these conditions are present and, if so, to what degree.

### ORTHOPEDIC

Spinal Fusion  
Spinal Instabilities/Abnormalities  
Alantoaxial Instabilities  
Scoliosis  
Kyphosis  
Lordosis  
Hip Subluxation and Dislocation  
Osteoporosis  
Pathologic Fractures  
Coxas Arthrosis  
Heterotopic Ossification  
Osteogenesis Imperfecta  
Cranial Deficits  
Spinal Orthoses  
Internal Spinal Stabilization  
Disease

### MEDICAL / SURGICAL

Cancer  
Poor Endurance  
Recent Surgery  
Diabetes  
Peripheral Vascular Disease  
Varicose Veins  
Hemophilia  
Hypertension  
Serious Heart Condition  
Stroke (Cerebrovascular  
Accident  
Allergies

### NEUROLOGIC

Hydrocephalus/shunt  
Spina bifida  
Tethered Cord  
Chiari Malformation  
Hydromyelia  
Paralysis due to Spinal Cord  
Injury  
Seizure Disorders

### SECONDARY CONCERNS

Behavior Problems  
Age under 2 years  
Age 2 - 4 years  
Acute exacerbation of Chronic disorder  
Indwelling catheter



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### Participant Registration and Photo Release

PARTICIPANT NAME:	DATE OF BIRTH:	AGE:	SEX: M F
ADDRESS:	CITY:	STATE / ZIP	
Home phone:	Cell phone:	E-mail	
Parent (custodial)/ Guardian/Caregiver:	Address if different:	Phone if different:	
School or programs presently attending:			
Please describe any previous experience with horses / riding ( no experience is required):			

### *Photo Release*

**(YOU MUST CHECK ONE BELOW) do not leave blank**

- I do consent
- I do not consent

to and authorize the use and reproduction by Faith Equestrian Therapeutic Center of any and all photographs and any other audio-visual materials taken of me / my child for promotional material, educational activities, exhibitions or for any other use for the benefit of the program.

**Please sign below confirming your choice:**

Date: \_\_\_\_\_ Signature: \_\_\_\_\_  
(Participant or parent/guardian if under 18)





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## GENERAL ACTIVITY RELEASE, ASSUMPTION OF RISK and WAIVER OF LIABILITY AGREEMENT

*This document waives important legal rights. Read it carefully before signing.*

I AGREE for my child, and/or administrators, my /our assigns, in consideration for my, and/or my child's, and myself participation in Faith Equestrian Therapeutic Center activity of the following:

I AGREE that I choose to participate voluntarily in Faith Equestrian Therapeutic Center activities as a rider, handler or spectator. I am fully aware and acknowledge that horse sports and Faith Equestrian Therapeutic Center activities involve inherent dangerous risks of accident, loss, and serious bodily injury including, but not limited to, broken bones, head injuries, trauma, pain, suffering or death ("Harm"). I fully understand that this release covers, but is not limited to, inherent risks of an equine activity, which mean a danger, or condition that is an integral part of an equine activity, including but not limited to, any of the following:

- ❖ The propensity of an equine to behave in ways that may result in injury, death, or loss to persons on or around the equine;
- ❖ The unpredictability of an equine's reaction to sounds, sudden movement, unfamiliar objects, persons, or other animals;
- ❖ Hazards, including, but not limited to, surface or subsurface conditions;
- ❖ A collision with another equine, another animal, a person, or an object;
- ❖ The potential of an equine activity participant to act in a negligent manner that may contribute to injury, death, or loss to the person of the participant or to other persons, including but not limited to, failing to maintain control over an equine or failing to act within the ability of the participant.

I AGREE that I/my child/my ward would like to participate in the Faith Equestrian Therapeutic Center program. I acknowledge the risks and potential risks; however, I feel that the possible benefits to me / my child / my ward are greater than the risk assumed. I hereby, intending to be legally bound for myself, my heirs and assigns, executors or administrators waive and release forever all claims for damages against Faith Equestrian Therapeutic Center, it's Board of Directors, instructors, therapists, aides, volunteers, employees, Twin Pines Farm, and affiliated organizations for any and all injuries and/or losses I may sustain while participating in the Faith Equestrian Therapeutic Center program including activities occurring outside of the scope of the program itself, including, but not limited to transportation, care giving, horse exercising etc.

By signing below, I ACKNOWLEDGE that I enter into this release after having read the same, and place my signature hereto of my own free voluntary act and deed. By signing below, I represent to Faith Equestrian Therapeutic Center that I fully understand its contents, that I do not need any further explanation, and I waive any further explanation.

I AGREE to assume all risks of Harm to me and / or my child, and specifically agree to the [GEORGIA LIABILITY LAW](#) regarding equine / farm animal activity liability: Under Georgia Law, an equine activity sponsor or equine professional is not liable for an injury to or the death of a participant in an equine activity resulting from an inherent risk of equine activity, **chapter 12, Title 4 of the official code of Georgia annotated.**

ACCEPTED BY: (if under the age of 18 years old, there must be a legal guardian signature below):

**Both date and signature MUST be completed.**

<b>PARTICIPANT Name (Printed):</b>	<b>Date:</b>
<b>( both parents must sign if there is " joint" custody of child)</b>	
<b>PARTICIPANT Signature / Legal Guardian Signature(s) if participant is under 18 years old:</b>	