



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

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.

We thank you for your interest and look forward to serving you soon. You may mail in your completed forms or email to programs.fetc@gmail.com. Please feel free to contact the office if you have any questions at (912)-728-3728 Monday through Friday 9am -5pm or Saturday 9am-3pm.

Sincerely,

Bonnie Rachael / CEO



Faith Equestrian 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.

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.

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. If the instructor believes the safety of the participant, horse, or volunteers is at risk.

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 volunteers commit their time to ensure a safe ride, we request as much notice as possible with a minimum of 24 hours notice unless it is an emergency.



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. 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 of Faith Equestrian’s policies, including eligibility and discharge of participants, absence policy and confidentiality policy.

Participant Name _____

Participant Signature _____

Date _____

Or

Parent/ Guardian Signature _____

Date _____

(If participant is under 18)

Photo Release

(YOU MUST CHECK ONE BELOW) do not leave blank

- I do consent
- I do not consent

Faith Equestrian Therapeutic Center 1)to use my (my child’s) photograph or image in its print, online and video publications; 2) release Faith Equestrian Therapeutic Center, its employees and any outside parties from all liabilities or claims that I might assert in connection with the above-described activities and 3) waive any right to inspect, approve or receive compensation for any materials or communications, including photographs, videotapes, DVDs, website images or written materials, incorporating photos/images of me(my child)

Please sign below confirming your choice:

Date: _____ Signature: _____

(Participant or parent/guardian if under 18)



Participant Registration

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:
If I Cannot be Reached Contact:	Phone:		Phone
If I Cannot be Reached Contact:	Phone:		Phone
School or programs presently attending:			
Please describe any previous experience with horses / riding (No experience is required):			
Describe Rider GOALS (i.e., why are you applying for participation? What would you like to accomplish?)			
Describe Physical Function (e.g., mobility skills such as transfers, walking, wheelchair use, driving/bus riding)			
Describe Psycho-social Function (e.g., work/school including grade completed, leisure interests, relationships-family structure, support systems, companion animals, fears/concerns, etc.)			



Faith Equestrian Therapeutic Center Inc.

Horses Helping People Help people



Client Medical History & Physicians' Statement

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Participant Name:	*Height:	*Weight:
Diagnosis:	Date of Onset:	

Medications: _____

Past/Prospective Surgeries: _____

Shunt Present? Y N Date of last revision: _____

Special Precautions, Diets/Needs/Allergies _____

___ May participate in all activities ___ May participate except for: _____

Mobility: Independent Ambulation? Y N Assisted Ambulation? Y N Wheelchair? Y N

Braces/Assistive Devices: _____

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

AREA	YES	NO	COMMENTS
Auditory			
Visual			
Tactile Sensation			
Speech			
Skin			
Cardiac			
Circulatory			
Learning Disability			
Mental Impairment			
Allergies			
Immunity			
Pulmonary			
Neurologic			
Muscular			
Orthopedic			
Cognitive			
Emotional/Psychological			
Other			

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).

Licensed Medical Examiner's Signature:	Date of EXAM:
Name (please print):	Phone:
Address:	Email:

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



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:

Licensed Medical Examiner's Signature:	Date of EXAM:
Physician's Name (please print):	Phone:
Address:	

*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 Not 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:



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



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.

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



Authorization of Emergency Medical Treatment

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.

Form with fields for Physician's Name, Phone, Preferred Medical Facility, Health Insurance Company, Policy*, Consent Plan, Consent Signature, Date, Non-Consent Plan, Non-Consent Signature, and Date.

Additional Release of Information

I _____, authorize Faith Equestrian Therapeutic Center to release the following information about the participant: _____,

I will allow the following information to be released (check all that apply):

- ___ Name
___ Age/Basic Description
___ Testimonial/Riders' progress made through Therapeutic Riding
___ Other (please describe) _____

This information may be released to (check all that apply):

- ___ Newspaper
___ News Media
___ Website
___ Other organization (such as Special Olympics)
___ Magazine or other Publication
___ Flyer

By signing this form, I am agreeing to allow the information described to be released regarding the participant to the designated parties.

Name of Participant _____

Signature (Parent or Guardian if under 18) _____ Date _____