FETC Therapeutic Riding Forms

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.
- Physician's cover letter and medical history & physician's statement must be completely filled out, dated and signed by the participant's physician, 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

Note: Dr. Heneisen with New Concepts Healthcare in Rincon will provide free medicals for participation in the FETC program, (912) 826-2132.

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

FETC TR Rider Guidelines

1. The FETC weight limit is **225** for balanced riders (able to stand on one leg, walk up stairs without assistance, or other qualifications as determined by instructor) unbalanced riders must weigh no more than **175**.

2. Riders must wear close-toed shoes (boots preferred). Long pants are recommended on rider lesson days. Please dress your child appropriately to the weather.

3. Riders will be required to wear appropriately fitting riding helmets. Riders must have a hairstyle that will not interfere with the fit of the helmet (coming down over the rider's forehead) or one that allows for the instructor to change it.

4. Riders may not participate in riding without a completed physical form every two years. Riders with Down Syndrome must complete a form yearly.

5. Lessons will continue in the case of rain. However, in the case of severe weather such as extreme heat, thunderstorms, hurricane or very windy conditions, lessons are to be cancelled at the discretion of FETC. FETC will also cancel lessons if the temperature high for the day is below 40 degrees. These lessons will not be made up.

6. Riders must give a minimum of 24 hours notice if they need to cancel a lesson. More time is better so we can alert the volunteers. **After three lessons are missed in a session without appropriate notice, that rider will be asked to sit out of the rest of a session.**

7. If a rider is 15 minutes late, the rider's horse will be untacked and they will be unable to ride that day.

8. Parents must remain with any siblings at all times and should not allow them to wander unattended. They must watch in the parent station or remain in their car without interfering with the lesson.

9. If volunteers do not show up, parents may be asked to sidewalk in a class so please consider bringing appropriate shoes.

Please sign below saying that you have read the above guidelines and understand them.

Signature: _____ Date: _____

Ineligibility and Discharge of Riders

Unfortunately, riding is not an appropriate activity for everybody and we occasionally have to decline or discontinue services to those to whom riding is inappropriate. As a PATH program we follow the PATH standards 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
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 for unbalanced riders and 225 for balanced riders.

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. Based on other factors such as cognitive skills or balance, which may cause riding to be 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 enrollment at FETC, the instructor believes that therapeutic riding is no longer applicable to the participant, the instructor has the right to discharge them. 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.

Confidentiality Policy

I understand that information about the participant (Name, goals, progress notes, etc.) will remain confidential unless the appropriate release of information form is signed. 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)

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 if under 18:	Address if different:		Phone if different:
If I Cannot be Reached Contact:	Phone:		Phone
If I Cannot be Reached Contact:	Phone:		Phone
Ethnicity (for grant purposes):			
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.)			

Photo Release

(YOU MUST CHECK ONE BELOW) do not leave blank

- o I do consent
- o 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)

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.

Physician's Name:	Phone:	Preferred Medical Facility:
Health Insurance Company:	Policy*:	

Consent Plan

Signing this gives consent to an 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:

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 the agency. In the event emergency treatment/aid is required, I wish the following procedures to take place:

_____

_____

_____

Non-Consent Signature: (Client, Parent or Guardian):	Date:

INFORMATION FOR PHYSICIAN

The following conditions, if present, may represent precautions or contraindications to therapeutic horseback riding. Therefore, when completing the below 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

Hydorcephalus/shunt
Spina bifida
Tethered Cord
Chiaril 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

Client Medical History & Physicians' Statement

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

*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?

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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

Note that the following are contraindications to riding:

- Recent seizure activity accompanied by strong, uncontrollable motor activity or atonic or drop attack seizures due to their sudden and complete loss of postural muscle tone
- A change of frequency or type of seizure until the condition is evaluated
- Inability to manage a participant during an emergency dismount should a seizure occur.

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:

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:**
PARTICIPANT Signature / Legal Guardian Signature(s) if participant is under 18 years old:	

Participants Consent for 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

___Contact Information

___Age/Basic description

___Medical History (only to be released to designated Medical facility)

___Testimonials/Riders' progress made through Therapeutic Riding)

___Other (please describe) _____

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

___Newspaper/Magazine or other Publication to Promote Faith Equestrian

___Newsletter to FETC contacts

___Website/Social Media

___Other _____

Special Instructions:

_____

_____

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_____