



## Heaven's Gait Ranch, Inc.

### Participant Registration Packet & Release Forms

2024

Participant's Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Street Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

County: \_\_\_\_\_ Home Phone: (\_\_\_\_) \_\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_\_

Work Phone: (\_\_\_\_) \_\_\_\_\_ Email Address: \_\_\_\_\_

Participant's Ethnicity: \_\_\_\_\_ Gender: \_\_\_\_\_ Weight: \_\_\_\_\_ Height: \_\_\_\_\_

Primary Disability: \_\_\_\_\_ Other Disabilities: \_\_\_\_\_

Adaptations: \_\_\_\_\_

Is the Participant a U.S. Military Veteran? \_\_\_\_ Yes OR \_\_\_\_ No

If you answered Yes to the question above, which branch did you serve? \_\_\_\_\_

What are your dates of service? \_\_\_\_\_

Name of Parent/Guardian (if Participant is under 18 years old): \_\_\_\_\_

Parent/Guardian's Cell Phone: (\_\_\_\_) \_\_\_\_\_ Parent/Guardian's Work Phone: (\_\_\_\_) \_\_\_\_\_

Parent/Guardian's Place of Employment: \_\_\_\_\_ City: \_\_\_\_\_

Does the Participant qualify for Medicaid funding or long term support? \_\_\_\_ Yes OR \_\_\_\_ No

If you answered Yes to the question above, check which program applies to the participant, and write the name of his/or county and case manager:

- |   |               |                            |
|---|---------------|----------------------------|
| <input type="checkbox"/> Children's Long Term Support Waiver (CLTS) | County: _____ | Case Manager: _____        |
| <input type="checkbox"/> Community Care Options Program (CCOP)      | County: _____ | Case Manager: _____        |
| <input type="checkbox"/> Comprehensive Community Services (CCS)     | County: _____ | Service Facilitator: _____ |
| <input type="checkbox"/> Other: _____                               | County: _____ | Case Manager: _____        |

**Leave this Box Blank. (For HGR Staff Use Only During Participant's Intake Assessment)**

Based on all information provided, the Participant will be enrolled in the following program at HGR:

- ☐ Equine Services for Heroes
- ☐ Equine-Assisted Learning
- ☐ Therapeutic Riding



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Has the participant ever ridden a horse?      Circle: YES      or      NO

List of activities, sports, games, and/or reinforcements that the participant enjoys:

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List of activities, sports, games, objects etc. that the participant dislikes/fears:

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Physical Abilities (Mobility, transfer skills, walking): \_\_\_\_\_

Psycho/Social Abilities: \_\_\_\_\_

What benefits would you like to obtain through HGR's programs & services? List goals here:

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### Photo Release

(Please check one):

I do \_\_\_\_\_ / I do NOT \_\_\_\_\_ consent to and authorize the use and reproduction by Heaven's Gait Ranch of any and all photographs and any other audio/visual materials taken of me for promotional material, educational activities, exhibitions, or for any other use for the benefit of the organization.

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

(Participant, Parent or Guardian if under 18)

### Liability Release

\_\_\_\_\_ (Participant's Name) would like to participate in equine assisted services at Heaven's Gait Ranch. I acknowledge the risks and potential for risks of horseback riding and other equine assisted services. However, I feel the possible benefits of myself/my son/my daughter/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 Heaven's Gait Ranch, Inc., its Board of Directors, Instructors, Trainers, Therapists, Aides, Volunteers, and/or Employees for any and all injuries and/or losses I/my son/my daughter/my ward may sustain while participating in programs at Heaven's Gait Ranch.

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

(Participant, Parent or Guardian if under 18)



## Heaven's Gait Ranch, Inc.

### Participant Registration Packet & Release Forms

#### Rider's Authorization/Emergency Medical Treatment

In the event of an emergency that 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 Heaven's Gait Ranch to do the following: 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.

#### Emergency Contact Numbers

Primary Contact in case of emergency: \_\_\_\_\_ Phone: \_\_\_\_\_  
Secondary Contact in case of emergency: \_\_\_\_\_ Phone: \_\_\_\_\_  
Physician's Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
Preferred Medical Facility: \_\_\_\_\_ City: \_\_\_\_\_  
Health Insurance Co: \_\_\_\_\_ Policy #: \_\_\_\_\_

#### 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 emergency contacts are unable to be reached.

Date: \_\_\_\_\_ Print Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Consent Signature: \_\_\_\_\_

(Participant, Parent or Guardian if Participant is under 18 years old)



## Heaven's Gait Ranch, Inc.

### Dear Health Care Provider:

Your patient \_\_\_\_\_

(Participant's Name)

is interested in participating in programs and/or services at Heaven's Gait Ranch, Inc. In order to safely provide our services under the Professional Association of Therapeutic Horsemanship (PATH Intl.), our center requests that you complete the attached Medical History and Physician's Statement Forms. Please note that the following conditions may suggest precautions and contraindications to mounted activities and/or therapeutic horseback riding.

Therefore, when completing this form, please note whether these conditions are present, and to what degree.

| Orthopedic  | Medical/Psychological                              |
|---|--|
| Atlantoaxial Instability (include neurologic symptoms)        | Allergies  |
| Coxarthrosis  | Animal Abuse                                       |
| Cranial Defects   | Cardiac Condition                                  |
| Heterotopic Ossification/Myositis Ossificans                  | Physical/Sexual/Emotional Abuse                    |
| Joint subluxation/dislocation                                 | Blood Pressure Control                             |
| Osteoporosis  | Dangerous to Self or Others                        |
| Pathologic Fractures  | Exacerbations of Medical Conditions (e.g., RA, MS) |
| Spinal Joint Fusion/Fixation                                  | Fire Setting                                       |
| Spinal Joint Instability/Abnormalities                        | Hemophilia   |
| <b>Neurologic:</b>  | Medical Instability                                |
| Hydrocephalus/Shunt   | Migraines  |
| Seizure   | PVD  |
| Sensory Deficit   | Respiratory Compromise                             |
| Spina Bifida/Chiari II Malformation/Tethered Coed/Hydromyelia | Recent Surgeries                                   |
| <b>Other:</b>   | Substance Abuse                                    |
| Age (under 4 years)   | Thought Control Disorders                          |
| Indwelling Catheters/Medical Equipment                        | Weight Control Disorder                            |
| Medications (e.g., photosensitivity)                          |  |
| Poor Endurance  |  |
| Skin Breakdown  |  |



## Heaven's Gait Ranch, Inc.

### Participant's Medical History

**\*Note: The participant's physician must complete this form. Parent/Guardian signature is also required.**

Participant's Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Address: \_\_\_\_\_

Primary Diagnosis: \_\_\_\_\_ Date of Onset: \_\_\_\_\_

Current Status: \_\_\_\_\_

Secondary Diagnosis: \_\_\_\_\_ Date of Onset: \_\_\_\_\_

Current Status: \_\_\_\_\_

Past Surgeries: \_\_\_\_\_ Date: \_\_\_\_\_

Prospective Surgeries: \_\_\_\_\_ Date: \_\_\_\_\_

Medications (include prescription and over-the-counter, name, dose, and frequency):

\_\_\_\_\_  
\_\_\_\_\_

Side Effects: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Does this participant have a history of seizures? Yes: \_\_\_\_\_ No: \_\_\_\_\_

If yes, please provide the following information.

Triggers: \_\_\_\_\_ Type of Seizure: \_\_\_\_\_

Controlled: Yes: \_\_\_\_\_ No: \_\_\_\_\_ Date of Last Seizure: \_\_\_\_\_

Shunt Present: Yes: \_\_\_\_\_ No: \_\_\_\_\_ Date of last revision: \_\_\_\_\_

Special Precautions/Needs: \_\_\_\_\_

Mobility Assessment:

Independent Ambulation: Yes: \_\_\_\_\_ No: \_\_\_\_\_

Assisted Ambulation: Yes: \_\_\_\_\_ No: \_\_\_\_\_

Wheelchair: Yes: \_\_\_\_\_ No: \_\_\_\_\_

Braces/Assistive Devices: \_\_\_\_\_

Date of last Atlantoaxial Instability neurologic exam: \_\_\_\_\_

(if participant has Down Syndrome)

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

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

Signature of Participant / Parent or Guardian (if participant is under 18 years old)



## Heaven's Gait Ranch, Inc.

### Participant's Physician's Statement

**\*Note: The participant's physician must complete this form.**

Please complete the following chart based on your knowledge of this participant.

Does the participant have a history of concerns in the following areas? Indicate yes or no. Add comments to explain.

| Category           | Yes | No | Comments | Category            | Yes | No | Comments |
|--------------------|-----|----|----------|---------------------|-----|----|----------|
| Auditory           |     |    |          | Muscular            |     |    |          |
| Visual             |     |    |          | Balance             |     |    |          |
| Tactile Sensation  |     |    |          | Orthopedic          |     |    |          |
| Speech             |     |    |          | Allergies           |     |    |          |
| Cardiac            |     |    |          | Learning Disability |     |    |          |
| Circulatory        |     |    |          | Cognitive           |     |    |          |
| Integumentary/Skin |     |    |          | Emotional           |     |    |          |
| Immunity           |     |    |          | Psychological       |     |    |          |
| Pulmonary          |     |    |          | Pain                |     |    |          |
| Neurologic         |     |    |          | Other               |     |    |          |

Additional Comments:

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### Physician's Statement

Given the above diagnosis and medical information, this person is not medically precluded from participation in equine-assisted activities. I understand that the PATH International center will weigh the medical information given against the existing precautions and contraindications. Therefore, I refer this person to the PATH International center for ongoing evaluation to determine eligibility for participation.

Name/Title: \_\_\_\_\_ MD DO NP PA Other: \_\_\_\_\_

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

Address: \_\_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_\_ EXT \_\_\_\_\_ License/UPIN Number: \_\_\_\_\_



## Heaven's Gait Ranch, Inc.

### Participant Safety Policies & Agreement

To ensure the quality and safety of our therapeutic riding lessons for our riders, volunteers, and horses, we have established the following policies at Heaven's Gait Ranch. Please read and sign the agreement below.

#### Riders

- Any rider 150 pounds or more must be able to independently remain centered and balanced on his or her horse so that side walkers are not required for primary physical assistance.
- Heaven's Gait Ranch reserves the right to determine whether mounted or unmounted equine activities are safe and appropriate for both horse and rider. This may vary from week to week.
- If a person is not eligible for therapeutic horseback riding, Heaven's Gait Ranch offers alternative equine-assisted activities that do not require mounting. Participants may still build relationships with our horses by grooming, feeding, bathing, and caring for them in a safe environment.
- All participants must wear an approved riding helmet (ASTM-SEI Certified) during equine activities, both mounted and/or ground. Helmets are provided by Heaven's Gait Ranch for participant use. Staff assist with proper fit and adjustments prior to the start of each lesson.
- Because safety and consistency come first at HGR, riders may be dismissed from our program for the following reasons. This determination will be made by Instructors and the Program Coordinator. If a rider is dismissed from HGR's program, a prorated refund will be issued.
  - A rider, his or her guardian, or visitor engages in unsafe, combative, or disruptive behavior toward staff, volunteers, or horses.
  - A rider, his or her guardian, or visitor does not follow HGR's policies & procedures on site.
  - A rider's deteriorating health begins to contraindicate horseback riding.
  - A rider misses three consecutive, unexcused absences (unless for medical reasons)
  - A rider, his or her guardian, or visitor is destructive to property at Heaven's Gait Ranch.
  - A rider, his or her guardian, or visitor attends their scheduled lesson time under the influence of illicit drugs or alcohol

#### Horses

- As our horses age, we must be conscious and considerate of their needs, just as we would for our riders. For most of our horses, therapeutic riding has become their second, third, or even fourth career; therefore, some require weight limits for health reasons. The staff and volunteers at HGR strive to keep all of our horses healthy, safe, and sound; however, there may be times when the horses available may not be suitable for certain riders. This determination will be made on an ongoing basis, and HGR will adjust teams accordingly.
- If a horse's health no longer permits him to safely perform mounted activities, staff, volunteers, and participants at Heaven's Gait Ranch will care for him through nurturing and meaningful groundwork as he enjoys retirement.

The staff, volunteers, and horses at Heaven's Gait Ranch thanks you in advance for adhering to these safety standards!

### Participant Safety Agreement

I have read the rider safety policies at Heaven's Gait Ranch. I understand the expectations for participants, riders, their parents or guardians, and visitors at this PATH International Member Center.

\_\_\_\_\_  
Participant /Parent/Guardian's Signature (if participant is under 18 years old)

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



## Heaven's Gait Ranch, Inc.

### HGR's 2024 Program Fees & Cancellation Policy Agreement

- Equine Services for Heroes
  - US Military Veterans participate for FREE at Heaven's Gait Ranch.
  - Lessons are sponsored 100% by the generosity of our donors.
- Equine Assisted Learning\* for Individuals with Special Needs or Disabilities:
  - \$158.50 for a 45 minute group lesson
  - \$178.50 for a 45 minute private lesson
  - Families who private pay should inquire about HGR's scholarship funding.
- Therapeutic Riding\* for Individuals with Special Needs or Disabilities:
  - \$158.50 for a 45 minute group lesson
  - \$178.50 for a 45 minute private lesson
  - Families who private pay should inquire about HGR's scholarship funding.
- \*Heaven's Gait Ranch offers heavily subsidized scholarships for families who privately pay and qualify for financial assistance. Families with questions on how to apply should inquire with our Program Coordinator about the Andy Mueller Memorial Scholarship. Available funds vary by season.

### HGR's Cancellation Policy

Occasionally HGR will cancel lessons due to extreme weather or on site working conditions; participants will not be charged whenever HGR initiates a cancellation. When it's raining/snowing, alternative activities are safely planned for the day in the barn, which may include unmounted activities or telehealth, remote services. All staff come to work because they're expecting their participants to show. The lesson fee is the same whether the participant engages in mounted or unmounted activities.

**If a participant cancels within 24 hours of their scheduled lesson time, then the participant is personally charged for the full cost of the lesson. This includes families who pay out of pocket, participants on scholarship, and participants funded by county agencies. We understand that health emergencies arise; however, if a participant misses three consecutive lessons, then they will lose their allotted day and time for the remainder of the session. Participants may not begin a new session with an outstanding balance from previous lessons provided or last minute cancellations initiated by the participant/family.**

### Participant Cancellation Policy Agreement

I read and acknowledge the information written above, including HGR's Program Fees & Cancellation Policy. I understand HGR's policy, and I agree to privately pay for the full cost of my lesson if/when I cancel within 24 hours of my scheduled lesson time.

\_\_\_\_\_  
Participant/Parent/Guardian's Signature (if participant is under 18 years old)

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