



# GALLOPING ACRES FOUNDATION, INC. RIDER PACKET

## GENERAL INFO

GALLOPINGACRES.com  
11353 Rocky Ridge Rd  
Glen Allen, VA 23059

RIDER NAME \_\_\_\_\_ AGE \_\_\_\_\_ DATE OF BIRTH \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**RIDING EXPERIENCE:**  NONE  VERY LITTLE  NOVICE  INTERMEDIATE

HEIGHT \_\_\_\_\_ WEIGHT \_\_\_\_\_ DATE OF MOST RECENT PHYSICAL EXAM \_\_\_\_ / \_\_\_\_ / \_\_\_\_

PARENT or LEGAL GUARDIAN \_\_\_\_\_

(\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  CELL  HOME  WORK (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  CELL  HOME  WORK

EMAIL ADDRESS \_\_\_\_\_

ALT EMERGENCY CONTACT \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

(\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  CELL  HOME  WORK (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  CELL  HOME  WORK

ALT EMERGENCY CONTACT \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

(\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  CELL  HOME  WORK (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  CELL  HOME  WORK

**RIDERS GENERAL MEDICAL INFORMATION** (detailed information to be provided on **pages 7 & 8**):

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

How did you hear about the Therapeutic Riding Program? \_\_\_\_\_

**GOALS:** (i.e. Why are you applying for participation? What would you like to accomplish?)

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

*I have been instructed and I am aware of the dangers of not wearing an ASTM/SEI approved helmet when mounted and riding a horse. Therefore, I choose to wear ASTM/SEI helmets at all times*

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Parent/Guardian name (please print) Signature Date



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## Emergency Medical Consent Form

If you were unable to be reached and your child needed emergency medical treatment, do you know what would happen? Medical providers are prohibited by law from providing most kinds of emergency treatment without prior written consent. To ensure that your child always receives the necessary care, please complete this emergency medical consent form. Give an original to your child's caretaker and instruct them as to where to go in an emergency. Some hospitals supply these forms and will keep them on file. Check with your hospital. In addition to this consent form, it is recommended you list personal, medical, insurance information and emergency contacts. Keeping a consent form with your child will ensure that they will receive emergency medical care whether you can be reached or not. To avoid such a situation, always leave instructions on where you will be and how you can be reached.

### TO EMERGENCY MEDICAL PROVIDERS

This is to authorize emergency treatment and/or transportation for \_\_\_\_\_ (RIDER)

SSN \_\_\_\_\_ DOB \_\_\_\_ / \_\_\_\_ / \_\_\_\_ HEIGHT \_\_\_\_\_ WEIGHT \_\_\_\_\_

ALLERGIES \_\_\_\_\_

PERTINENT MEDICAL INFORMATION (ongoing medical conditions, recent treatments for physical/mental conditions)

INSURANCE PROVIDER \_\_\_\_\_ GROUP # \_\_\_\_\_

INSURANCE PHONE # \_\_\_\_\_ SUBSCRIBER EMPLOYER \_\_\_\_\_

SUBSCRIBERS NAME \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

HOME ADDRESS: \_\_\_\_\_  
STREET (and unit) \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP CODE \_\_\_\_\_

EMERGENCY CONTACT \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

( ) \_\_\_\_\_ - \_\_\_\_\_  CELL  HOME  WORK ( ) \_\_\_\_\_ - \_\_\_\_\_  CELL  HOME  WORK

EMERGENCY CONTACT \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

( ) \_\_\_\_\_ - \_\_\_\_\_  CELL  HOME  WORK ( ) \_\_\_\_\_ - \_\_\_\_\_  CELL  HOME  WORK

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, the undersigned, hereby authorize Galloping Acres Foundation, INC Therapeutic Riding Center 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. 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) below is unable to be reached.

Parent/Guardian name (please print) \_\_\_\_\_ Signature \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Date

Parent/Guardian name (please print) \_\_\_\_\_ Signature \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Date

Witness name (please print) \_\_\_\_\_ Signature \_\_\_\_\_ Telephone Number \_\_\_\_\_

Witness name (please print) \_\_\_\_\_ Signature \_\_\_\_\_ Telephone Number \_\_\_\_\_



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11353 Rocky Ridge Rd  
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## EQUINE ACTIVITY LIABILITY RELEASE, WAIVER OF RIGHT TO SUE AND ASSUMPTION OF ALL RISK

I, the undersigned participant, hereby agree to the provisions of this Equine Activity Liability Release, Waiver of Right to Sue and Assumption of All Risk Agreement ("this Agreement") with GALLOPING ACRES, LLC (the "Equine Professional") and TALL CEDARS FARM, INC. (the "Owner"), on behalf of myself and each and every minor participant for whom I am signing this Agreement (as named below), as follows:

1. I/we agree to follow all instructions given or rules established by the Equine Professional or any of the Equine Professional's employees or other agents concerning my/our use of any horse or of any equipment or gear provided by the Equine Professional. It is highly recommended for safety reasons that a riding helmet be worn while engaged in equine activities.

Please indicate whether or not you desire to wear a riding helmet:  YES  NO Initials \_\_\_\_\_. I hereby accept full responsibility for all injuries that might occur as a result of failure to wear a riding helmet.

2. I/we have full and complete notice and understanding of the many risks inherent in equine activities which may cause, contribute to or result in SERIOUS INJURY OR EVEN DEATH or damage to property (the "Risks"), regardless of previous training and past performance of the horse including but not limited to the following:

(a) Horses have a propensity to behave in dangerous ways; (b) It is not expected that anyone will be able to predict or foresee a horse's reaction to excitement, weather conditions, sound, movements, objects, persons, animals, reptiles, birds or insects, nor the effects of any such reactions; (c) Surface and subsurface conditions pose many potential hazards, both obvious and hidden; (d) There is always a risk that tack or harness may slip or break or that the horse or the participant may

become entangled in tack, harness or vehicles used in an equine activity; and (e) There is a risk of the participant falling from or otherwise becoming unstable on a horse or a vehicle used in an equine activity or for the horse to trip and/or fall down without warning.

3. I/we have full and complete notice and understanding that this Agreement and all equine activities provided by the Equine Professional are governed by the Virginia Equine Activity Liability Act (Code of Virginia §3.1-796.130, §3.1-796.132, §3.1-796.133 et seq., Please see exhibit A), as it may now provide or be hereafter amended ("the Act"), which Act is hereby incorporated in this Agreement by reference; that all terms defined by the Act shall have the same meaning herein; and that this Agreement shall be so construed as to provide to the Equine Professional the fullest protection of a release, waiver of right to sue and assumption of all risk which is afforded by the Act.

4. I/we hereby RELEASE and WAIVE all rights which I/we may have or may hereafter have against the Equine Professional and/or the Owner for death, personal injury or property damage which is in any way associated with the Risks or otherwise covered under the Act; I/we hereby WAIVE any right to sue or to bring any action against the Equine Professional and/or the Owner in connection therewith including any negligent act or omission by either of them or by any employee or agent of either of them; I/we hereby agree to INDEMNIFY and HOLD HARMLESS the Equine Professional and/or the Owner from and against any such suit or action and agree to pay any attorney fees which may arise if any such suit or action is filed; and I/we hereby expressly ASSUME ALL RISKS AN) DANGERS of death, personal injury and property damage which are in any way associated with the Risks or otherwise covered under the Act.

5. I/we hereby authorize and consent to any emergency medical care which may be administered as a result of injury or sickness caused by or incurred in the course of any equine activity.

6. To the extent possible, this Agreement shall be construed in such manner as will render each provision fully enforceable; but if any provision of this Agreement shall be unenforceable, such provision (or so much thereof as is unenforceable) shall be deleted and the remainder of this Agreement shall continue in full force and effect.

**Initials** \_\_\_\_\_

7. If this Agreement is executed for and on behalf of a minor participant named below, the undersigned participant hereby warrants and represents that he or she is in fact the legal parent or guardian of such minor, with full rights of custody and control; that this Agreement is given on behalf of and is intended to be binding upon said minor participant, his heirs, personal representatives, successors and assigns. in any event, this Agreement shall be binding upon the heirs, personal representatives, successors and assigns of the participant.

8. Each and every right and benefit of the Equine Professional and/or the Owner hereunder shall also accrue to the benefit of each officer, agent, employee, director, shareholder, member, partner, heir-at-law, personal representative, successor and assign of the Equine Professional and the Owner including without limitation every waiver, release, indemnification and agreement to hold harmless.

I HAVE FULLY READ AND FULLY UNDERSTAND THE FOREGOING EQUINE LIABILITY RELEASE, WAIVER OR RIGHT TO SUE AND ASSUMPTION OF ALL RISKS. I HAVE HAD AN OPPORTUNITY TO CONSULT WITH MY OWN ADVISORS ON ALL QUESTIONS IN CONNECTION THEREWITH, AND I HAVE NOT RELIED UPON THE EQUINE PROFESSIONAL OR THE OWNER FOR ANY ADVICE OR EXPLANATION IN CONNECTION THEREWITH. I ACKNOWLEDGE THAT I HAVE A COPY AND HAVE A FULL AND COMPLETE UNDERSTANDING OF THE VIRGINIA EQUINE LIABILITY ACT. I UNDERSTAND THAT, BY SIGNING THIS DOCUMENT, I MAY BE WAIVING AND RELEASING CERTAIN IMPORTANT RIGHTS WHICH I MIGHT HAVE IF I DID NOT SIGN THIS AGREEMENT. I AM SIGNING THIS DOCUMENT FREELY, VOLUNTARILY AND WITHOUT ANY COERCION.

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Parent/Guardian name (please print) Signature Date





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11353 Rocky Ridge Rd  
Glen Allen, VA 23059

## PHOTO RELEASE

### Consent Release for Galloping Acres Foundation, INC.

Name: \_\_\_\_\_ (Student)

Signature: \_\_\_\_\_ (Parent/Guardian ~ if Student under 18)

Email Address \_\_\_\_\_

I DO consent to and authorize Galloping Acres Foundation and/or Hanover County Parks and Recreation to take or have taken still and/or moving photographs, films and/or television pictures, and consent and authorize Galloping Acres Foundation and/or Hanover County Parks and Recreation and/or its advertising agencies, television or news media and any other persons associated with the Galloping Acres Foundation and/or Hanover County Parks and Recreation, to use and reproduce the photographs, films, and/or pictures and to circulate and publicize the same by all means, including, without limiting the generality of the foregoing, news organizations, social media (i.e. Facebook), brochures, pamphlets, educational activities, exhibitions, instructional materials, books, and/or clinical materials. With respect to the foregoing matters, no inducements or promises have been made to me to secure my signature to this release other than the intention of Galloping Acres Foundation and/or Hanover County Parks and Recreation to use or cause to be used such photographs, films, and pictures for the **primary purpose of promoting and aiding Galloping Acres Foundation, INC and/or Hanover County Parks and Recreation for the benefit of the Therapeutic Riding program and its business.**

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

Signature: \_\_\_\_\_ (Student)

Signature: \_\_\_\_\_ (Parent/Guardian - if Student is under 18)

I DO NOT for reasons I am not obligated to disclose, give consent for photographs, either still or moving, for social media (i.e. Facebook) or any television or news media, to be taken of myself by Galloping Acres Foundation, INC and/or Hanover County Parks and Recreation or any persons working on behalf of Galloping Acres Foundation and/or Hanover County Parks and Recreation. I understand a Red Dot or other signifier will be placed on the sign-in sheet and/or on the rider to reflect photographs, etc., are NOT allowed.

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

Signature: \_\_\_\_\_ (Student)

Signature: \_\_\_\_\_ (Parent/Guardian - if Student is under 18)



# GALLOPING ACRES FOUNDATION, INC.

## RIDER PACKET

### MEDICAL

GALLOPINGACRES.com  
11353 Rocky Ridge Rd  
Glen Allen, VA 23059

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

Dear Physician:

Your patient, \_\_\_\_\_ (participant's name) is interested in participating in supervised equestrian activities provided by Galloping Acres Foundation, Inc & Hanover County Parks & Recreation Department. This program is accredited by the Professional Association of Therapeutic Horsemanship Intl. (P.A.T.H.) as a member center.

In order to safely provide this service, we request that you complete/update the attached Medical History (page 7) and Physician's Statement Form (page 8). Please note that the following conditions may suggest precautions and contraindications to therapeutic horseback riding. Therefore, when completing this form, please note whether these conditions are present, and to what degree.

#### Orthopedic

Atlantoaxial Instability- include neurologic symptoms  
Coxa Arthrosis  
Cranial Deficits  
Heterotopic Ossification/Myositis Ossificans  
Joint Subluxation/dislocation  
Osteoporosis  
Pathologic Fractures  
Spinal Fusion/Fixation  
Spinal Instability/Abnormalities  
Neurologic  
Hydrocephalus/Shunt  
Seizure  
Spina Bifida/Chiari II Malformation/Tethered Cord/Hydromyelia

#### Other

Age- under 4 years  
Indwelling Catheters  
Medications- i.e. photosensitivity  
Poor Endurance  
Skin Breakdown

#### Medical/Psychological

Allergies  
Animal Abuse  
Physical/Sexual/Emotional Abuse  
Blood Pressure Control  
Dangerous to self or others  
Exacerbations of medical conditions  
Fire Settings  
Heart Conditions  
Hemophilia Medical Instability  
Migraines  
PVD  
Respiratory Compromise  
Recent Surgeries  
Substance Abuse  
Thought Control Disorders  
Weight Control Disorder

Thank you very much for your assistance. If you have any questions or concerns regarding this patient's participation in therapeutic equine activities, please feel free to contact Shannon Lawson at 804-357-4231

Sincerely,

*Shannon Lawson*

Program Director

Certified Professional Association Therapeutic Horsemanship Intl. (P.A.T.H.) Registered Instructor

<https://pathintl.org/centers/galloping-acres-foundation-inc/>

<https://www.vhib.org/therapeutic-riding-programs>





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## MEDICAL

USE FOR: Galloping Acres Foundation, Inc. and/or Hanover County Parks & Recreation Therapeutic Riding Program and their authorized representatives only

Participant: \_\_\_\_\_ DOB: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

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

Diagnosis: \_\_\_\_\_

Date of Onset: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Past/Prospective Surgeries: \_\_\_\_\_

Medications (Including any OTC) and purpose:

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:  +  -

Neurologic Symptoms of AtlantoAxial Instability: \_\_\_\_\_



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## MEDICAL

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USE FOR: Galloping Acres Foundation, Inc. and/or Hanover County Parks & Recreation Therapeutic Riding Program and their authorized representatives only

Please indicate current or past difficulties in the following system/area, including surgeries:

	YES	NO	COMMENTS
Auditory	<input type="checkbox"/>	<input type="checkbox"/>	
Visual	<input type="checkbox"/>	<input type="checkbox"/>	
Tactile Sensation	<input type="checkbox"/>	<input type="checkbox"/>	
Speech	<input type="checkbox"/>	<input type="checkbox"/>	
Cardiac	<input type="checkbox"/>	<input type="checkbox"/>	
Circulatory	<input type="checkbox"/>	<input type="checkbox"/>	
Integumentary/Skin	<input type="checkbox"/>	<input type="checkbox"/>	
Immunity	<input type="checkbox"/>	<input type="checkbox"/>	
Pulmonary	<input type="checkbox"/>	<input type="checkbox"/>	
Neurologic	<input type="checkbox"/>	<input type="checkbox"/>	
Muscular	<input type="checkbox"/>	<input type="checkbox"/>	
Balance	<input type="checkbox"/>	<input type="checkbox"/>	
Orthopedic	<input type="checkbox"/>	<input type="checkbox"/>	
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	
Learning Disability	<input type="checkbox"/>	<input type="checkbox"/>	
Cognitive	<input type="checkbox"/>	<input type="checkbox"/>	
Emotional/Psychological	<input type="checkbox"/>	<input type="checkbox"/>	
Pain	<input type="checkbox"/>	<input type="checkbox"/>	
Other:			

To my knowledge, there is no reason why this person cannot participate in supervised equestrian activities. However, I understand that Hanover County Parks and Recreation and/or Galloping Acres Foundation INC. will weigh the medical information above against the existing precautions and contraindications.

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

License/UPIN Number: \_\_\_\_\_

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

Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Email: \_\_\_\_\_

Signature: \_\_\_\_\_ DATE: \_\_\_\_/\_\_\_\_/\_\_\_\_





# GALLOPING ACRES FOUNDATION, INC.

## RIDER PACKET

### POLICIES

GALLOPINGACRES.com

11353 Rocky Ridge Rd

Glen Allen, VA 23059

#### **Hanover County Parks & Recreation and Galloping Acres Foundation, Inc. Therapeutic Riding Program**

Hanover County Parks & Recreation and Galloping Acres Foundation, Inc. Therapeutic Riding Program will implement the following policies for the riding season. The following policies and procedures are critical to the safety of the participants, volunteers, instructors and horses. These policies are not flexible and will be followed to help promote an environment that will be safe, beneficial and fun for the participants. Please take the time to read and thoroughly understand these policies and procedures. Your signature acknowledges that you fully understand and will abide by all policies and procedures and will help keep the environment as safe as possible. Thank you for your understanding.

#### **Participation In/Discharge From Therapeutic Riding Classes:**

Recognizing that equine related activities hold inherent risks all new participants will be evaluated by PATH (Professional Association of Therapeutic Horsemanship Intl) Certified Instructors to ensure a safe and beneficial experience. In compliance with PATH guidelines and Galloping Acres Foundation, Inc. policy, participants must be at least 5 years of age; participant/parent/guardian must turn in all liability and medical forms, They must be complete, signed, and dated two weeks prior to the first lesson to give the instructors ample to time to review and plan a fun and safe lesson. Upon reviewing completed paperwork and evaluating prospective participants Galloping Acres Foundation, Inc. will make a determination regarding participation. Returning participants will be re-evaluated annually or as necessary for changes in medical, physical, cognitive and behavioral status. We will assess participant involvement with a risk/benefit analysis taking into consideration PATH Precautions and Contraindications noted in the program accreditation standards manual. Galloping Acres Foundation, Inc. instructors will make final determination for participation based on class availability, volunteer availability, and instructor expertise and horse suitability. Galloping Acres Foundation, Inc. reserves the right to discharge any rider from the program without notice. Reasons for discharge may include, but are not limited to the following: 1) Rider progresses to a level of skill that they may be better served by a riding program for non-disabled students, 2) Rider becomes too large or heavy for the program to serve safely, 3) Rider's condition or behavior becomes a threat to safety, 4) Program does not have suitable mount for rider.

#### **Volunteer Opportunities:**

Volunteers are the backbone of this program! If you or someone you know would like to help out during lessons, or with fundraising please contact a Galloping Acres Foundation, Inc. representative.

#### **Fee:**

\$300 per session for a six week program.

#### **Financial Assistance:**

There is a limited amount for partial or full financial assistance available each session. If you wish to request financial assistance, please contact Shannon Lawson at 804-357-4231 or by email [Shannon@gallopingacres.com](mailto:Shannon@gallopingacres.com) with the subject line GAF Financial Assistance for more details.

#### **Attendance:**

1. If a student is unable to attend a class, you must call Shannon Lawson at 804-357-4231 three hours prior to the class. Failure to call and notify your instructor more than twice will result in discharge from the program without refund.
2. If at any time you are unsure if lessons could be cancelled due to weather, please call Shannon Lawson at 804-357-4231.
3. Students should arrive 15 minutes prior to their scheduled class time.

#### **Late Arrivals:**

In order to conduct a beneficial and productive riding lesson, students arriving late (after the gate is closed) will not be mounted.

#### **Riding is contraindicated:**

1. If staff and volunteers are unable to safely manage the participant in any situation, including an emergency dismount.
2. If safety or comfort of the horse is compromised, the final determination for participation will be made by Galloping Acres Foundation, Inc.

#### **Weight Considerations:**

Weight is generally limited to 170 pounds, but decisions regarding participation will be based on the availability of a suitable horse relative to the height, cognition, and balance of the participant. The results of a risk/benefit analysis will also be considered.

Initial \_\_\_\_\_



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### POLICIES

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**Attire:**

1. ASTM-SEI approved helmets must be worn while mounted and during non-mounted grooming or barn activities and will be provided if necessary.
  - a. Students are strongly encouraged to purchase their own helmet to help reduce sanitary issues.  
We recommend the “Troxel, International or Tipperary Spoilage” Helmets.
  - b. Local Tack Shop: Champion Saddlery 15225 Breedens Road Doswell, VA 23047 804-227-3434
2. Students must wear long pants to protect their legs. Jeans or Sweat pants will work fine. Shorts are permitted only with chaps.
3. Students need to wear sturdy shoes with a heel or riding boots (NO sandals, and sneakers are not recommended).
4. Students may wear gloves during the lesson, to protect their hands from blisters and cold weather. Stretch gloves and leather gloves are most ideal.
5. Students should wear fitted clothes with shirttails tucked in.
6. Students with medium-long hair must their hair tied back in a low ponytail; no clips or barrettes allowed under helmets.
7. Students may not wear large earrings, necklaces, and/or bracelets.

**Parking/Observation Area:**

1. Please note the SPEED LIMIT of 5 MPH. Please park in designated parking area. This will vary from session to session. Siblings and parents should wait calmly and quietly in areas designated by the instructors so that lessons are not disrupted and to help promote a safe, non-distractive environment for the safety of the rider’s, horses, volunteers and instructors. Also, please do not wear open toed shoes. Any participant, parent, sibling, or volunteer who demonstrates behavior deemed inappropriate, disruptive or unsafe by any Galloping Acres Foundation, Inc. Instructor will be asked to leave the premises without warning. No dogs allowed on premises unless they live there.

**Typical Group Lesson Format (2-6 riders) 1 hour:**

1. Mount - Usually takes about fifteen minutes to safely mount four students
2. Warm-Up will begin after mounting, and will include walking around the ring
3. Exercises - 10 minutes
4. Body of Lesson (review) - 10 minutes
5. Games - 10 minutes
6. Closure - 10 minutes
7. Dismount - 5 minutes

Please note on the first lesson, it may take longer to begin the lesson due to properly fitting helmets, matching the right size horse to the rider, tack, and student.

\*\*\*\*Adjustments to the student or horse may be necessary at any time of the lesson to allow the best possible body alignment and comfort for the horse while riding.\*\*\*\*

\*Private Lessons are 30 minute sessions\*

**Please read and sign below.** I have read and understand the policies and procedures of the Hanover County Parks and Recreation Therapeutic Riding Program and Galloping Acres Foundation, Inc. held at Tall Cedars Farm, Inc. I have read all waivers and forms (TEN [10] PAGES) and have completed all requested information to the best of my knowledge.

Participant’s Full Name (Print Name) \_\_\_\_\_

Parent or Guardian (Print Name) \_\_\_\_\_

Parent or Guardian (Signature) \_\_\_\_\_ Date : \_\_\_\_/\_\_\_\_/\_\_\_\_