Student Name:_____ School:_____

GALEP Horse Masters Club

Galt Horse Assisted Learning &
Enrichment Program

Want to learn about horses and learn to ride?

GALEP is a therapeutic riding and after school horse-mastership program offered to students in the Galt Joint Union Elementary School District. Students learn about horse care and riding in a fun and safe environment. The GALEP facility is located on the McCaffrey Middle School campus, **997 Park Terrace Drive in Galt.**
For more information about GALEP visit the Galt Joint Union Elementary School District Website at https://www.galt.k12.ca.us/Programs/GALEP

SUMMER 2024

GALEP Horse Masters Club!

The club is on Wednesdays from 8:30-11:30am

Summer Session Dates: June 26th, July 3rd, 10th, 17th

- Transportation is **not** provided
- Availability is on a first come first serve basis
- Drop off /Pick up will be at the arena at McCaffrey Middle School
- This club is FREE!

  - I am interested in the Fall Session dates TBD!

Medical release forms are good for one year.
Applications can also be taken now for the fall 2024 program.

GALEP Applications, medical and release forms must be complete and turned in to Lori Jones prior to attending, at

The District Office:

1018 C Street, Suite 210 Galt CA, 95632
Please feel free to contact us at 209-744-4545 ext. 332

GALEP

Galt Horse-Assisted Learning and Enrichment Program

REGISTRATION/LIABILITY/PHOTOGRAPHIC RELEASE FORM

PATH INTERNATIONAL
Professional Association of Therapeutic Horsemanship International
—MEMBER—

1. REGISTRATION

I wish to register the following Student in the Galt Horse-Assisted Learning and Enrichment Program (GALEP), a free program available to Students of the Galt Joint Union Elementary School District (District):

Student:_____ Date of Birth:_____ Age:_____

School presently attending:_____ Current Grade: _____

Home Address:_____ City:_____

State:_____ Zip:_____ Home Telephone No.:_____

Emergency contact name:_____

Emergency contact Info: Work:_____ Email:_____

➡ Date:_____ Signature Parent/Legal Guardian:_____

2. LIABILITY RELEASE

There are inherent risks associated with horseback riding and interfacing with animals, including the unpredictability of the animals which will come into contact with the Student. There are also natural and man-made conditions at the contemplated riding sites that may present potential risks of physical injury, harm, damage or death. To the fullest extent allowed by law, applicable to both GALEP and District (and their respective employees, agents and/or volunteers), I acknowledge and accept all such known and unknown risks, as well as risks that may arise from the providing/non-providing of medical care or attention in response to any potential injury. I also waive and release for myself/the participating Student any potential claim for personal injury (up to and including death), property damage, and/or other harm, injury or loss.

➡ Date:_____ Signature Parent/Legal Guardian:_____

3. EMERGENCY MEDICAL CARE AUTHORIZATION

In the case of injury or suspected injury, I authorize the administration of urgent or emergency care to the Student, including the transportation of the Student to an urgent care or emergency care provider. Notice to me of an injury/suspected injury may be delayed such that any urgent or emergency care provider has my express authority to conduct diagnostic or anesthetic procedures and/or to provide medical care or treatment (including surgery) as they may deem reasonable or necessary under all circumstances. All costs and expenses associated with such care are solely my responsibility. Authorization to provide such emergency medical care is a requirement to participate in GALEP.

➡ Date:_____ Signature Parent/Legal Guardian:_____

4. PHOTO RELEASE

I hereby (select one): ☐ **consent** ☐ **do not consent**

To the photographing/videotaping of the Student and the use by GALEP and District of such photographs or videotapes for any purpose associated with the promotion of GALEP or GALEP's or the District's public benefit or educational activities or programs.

➡ Date:_____ Signature Parent/Legal Guardian:_____

GALEP - HORSEMANSHIP PROGRAM PHYSICAL EXAMINATION FORM

PART 1 (To be completed by a **parent/guardian)**

LAST NAME	FIRST NAME	

5. HEALTH HISTORY (Must be completed prior to the examination)

	Yes	No	Has this student had any:
1.	☐	☐	Chronic or recurrent illness?
2.	☐	☐	Illness lasting over 1 week?
3.	☐	☐	Hospitalizations or Surgery?
4.	☐	☐	Nervous, psychiatric, or neurologic condition?
5.	☐	☐	Loss or nonfunctioning of organs (eye, kidney, liver, testicle) or glands?
6.	☐	☐	Allergies (medicines, insect bites, food)?
7.	☐	☐	Problems with heart or blood pressure?
8.	☐	☐	Chest pain or severe shortness of breath with exercise?
9.	☐	☐	Dizziness or fainting with exercise?
10.	☐	☐	Fainting, bad headaches or convulsions?
11.	☐	☐	Concussion or loss of consciousness?
12.	☐	☐	Heat exhaustion, heatstroke, or other problems with heat?
13.	☐	☐	Racing heart, skipped, irregular heartbeats, or heart murmur?
14.	☐	☐	Seizures?
15.	☐	☐	Severe or repeated instances of muscle cramps?

Date of last known tetanus (lockjaw) shot: _____

Date of last complete physical examination: _____

	Yes	No	Does this student:
16.	☐	☐	Wear eyeglasses or contact lenses?
17.	☐	☐	Wear dental bridges, braces or plates?
18.	☐	☐	Take medications (prescription or non-prescription? (List):
19.	☐	☐	Have Down Syndrome?

	Yes	No	Is there any history of:
20.	☐	☐	Injuries requiring medical care or treatment?
21.	☐	☐	Neck or back pain or injury?
22.	☐	☐	Knee pain or injury?
23.	☐	☐	Shoulder or elbow pain or injury?
24.	☐	☐	Ankle pain or injury?
25.	☐	☐	Other joint pain or injury?
26.	☐	☐	Broken bones (fractures)?

	Yes	No	Further history:
27.	☐	☐	Birth defects (corrected or not)?
28.	☐	☐	Death of parent or grandparent less than 40 years of age due to medical cause or condition?
29.	☐	☐	Parent or grandparent requiring treatment for heart condition less than 50 years of age
30.	☐	☐	Been seen by a physician on an emergency or urgent basis in the last 12-months?

Explain all "YES" answers along with any other fact that should be disclosed before the examination (use reverse of form if needed):

PARENT/GUARDIAN'S AUTHORIZATION: I authorize a physician or duly authorized and supervised physician's assistant or nurse practitioner to perform a Horsemanship Program Physical Evaluation on the student. The information set forth above is complete and accurate and I know of no reason why the student cannot fully and safely participate in the Program as I understand it. I understand that this is solely a screening examination and that the absence of any health conditions or concerns listed below does not mean that student is free from actual or potential harmful health conditions that may cause the student injury or death while participating in the Program. Any question or concern I may have regarding the student's health or safety will be referred to our personal physician or health care provider for review and evaluation.

➡ **PRINT NAME OF PARENT OR GUARDIAN**	➡ **SIGNATURE OF PARENT OR GUARDIAN**		
ADDRESS	WORK PHONE	HOME PHONE	DATE
REGULAR PHYSICIAN'S NAME	OFFICE PHONE		

PART 2 (To be completed by the examining **physician/physician's assistant/nurse practitioner)**

	NORMAL	ABNORMAL (Describe)	DOB:
Eyes/Ears/Nose/Throat			Height:
Skin			Weight:
Heart			Gender:
Abdomen			BP:
Genital/hernia (males)			➡ ***One of the below MUST be checked.***
Musculoskeletal:			☐ Unlimited participation
a. Neck/Spine/Shoulders/Back			☐ Limited participation/activities allowed/denied (see below)
b. Arms/Hands/Fingers			☐ Clearance withheld pending further testing/evaluation
c. Hips/Thighs/Knees/Legs			☐ No participation
d. Feet/Ankles			
Neurologic Screening Exam (NSE)			

For a participant with Down Syndrome: A full radiological exam is required to establish the absence of Atlanto-axial Instability before he/she may participate in riding activities. **X-Ray Evaluation for Atlanto-axial instability Date:**_____ **Result:** + -

Comments*(use reverse of form if needed)*:

➡ **PRINT NAME OF PHYSICIAN** (M.D., D.O., P.A, or N.P. only)	➡ **PHYSICIAN'S SIGNATURE**	**DATE**