

Checked and Approved by:

\_\_\_\_\_

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



## New Kingdom Trailriders Rider UPDATE Form 2022

Rider Check List \_\_\_\_  
Chimp Mail \_\_\_\_  
Rider Contact \_\_\_\_  
Rider Emergency \_\_\_\_  
Quickbooks \_\_\_\_  
Equiforce \_\_\_\_  
Scanned \_\_\_\_  
Attached \_\_\_\_  
Ready to be Filed \_\_\_\_

\*Staff use only\*

Student Name: \_\_\_\_\_

Student Age: \_\_\_\_\_

Student Height: \_\_\_\_” \_\_\_\_’

Student Weight: \_\_\_\_\_ lbs

Student Gender: \_\_\_\_\_

Student Diagnosis/What qualifies student to be a rider:

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

Student's Riding Goals for 2021 (What rider wants to learn/work on):

- 1.
- 2.
- 3.

I have read the 2021 NKT Riders Handbook. By signing below, I indicate that I understand and agree with the NKT policies: \_\_\_\_\_

**New Kingdom Trailriders**  
**Medical History/Authorization for Emergency Medical Treatment Form**

\_\_\_ Participant    \_\_\_ Staff    \_\_\_ Volunteer

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Phone: \_\_\_\_\_

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

Street

City

State

Zip

Physician's Name: \_\_\_\_\_ Preferred Medical Facility: \_\_\_\_\_

Health Insurance Co: \_\_\_\_\_ Policy #: \_\_\_\_\_

Allergies to medications: \_\_\_\_\_

Current medications: \_\_\_\_\_

Medical History and Conditions/Special Accommodations Needed:

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

I have supplied the information requested above to the best of my knowledge and ability. The above information is up to date and current.

Participant/Parent/Legal Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**In the event of an emergency, contact:**

Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Phone: \_\_\_\_\_

In the event of 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 New Kingdom Trailriders 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.

**Consent Plan**

This authorization includes x-ray, surgery, hospitalization, medication and any treatment procedure deemed "lifesaving" by the physician. This provision will only be invoked if the person(s) above is unable to be reached.

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

Client, Parent or Legal Guardian

**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

- \_\_\_ Parent or legal guardian will remain on site at all times during equine assisted activities  
\_\_\_ In the event emergency treatment/aid is required, I wish the following procedure to take place.

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

Date \_\_\_\_\_

## NKT – STUDENT REGISTRATION FORM UPDATE – 2021

Student Name: \_\_\_\_\_

Student Contact information:

Preferred method of contact:                      Phone                      Email

**Primary Contact** (Self/Parent/Guardian):

Name: \_\_\_\_\_

Relationship to Student or Self: \_\_\_\_\_

Phone number: \_\_\_\_\_

Email: \_\_\_\_\_

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

**Secondary Contact** (Self/Parent/Guardian):

Name: \_\_\_\_\_

Relationship to Student or Self: \_\_\_\_\_

Phone number: \_\_\_\_\_

Email: \_\_\_\_\_

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

\*If there is an additional information you need to update it is your responsibility to email Monika at [Monika@nktriders.org](mailto:Monika@nktriders.org)