Checked and Approved by:

_____

*Date:*_____

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

Staff use only

New Kingdom Trailriders
Rider Forms Checklist
2023

____ Student Registration Form

____ Authorization for Emergency Medical Treatment

____ Medical Release

____ AAI Medical Release

____ General Liability Release

____ Mental Health History

____ Photo Release

____ Equine Liability Release

____ Handbook Agreement

____ Assumption of Risk Waiver

Revised December 2022

Date_____

New Kingdom Trailriders
STUDENT REGISTRATION FORM

Student Name _____

Primary Contact (Self/Parent/Guardian):

Name _____

Relationship to Student or Self: _____

Phone number _____

Email _____

Address & County _____

_____

Secondary Contact:

Name _____

Relationship to Student _____

Phone number _____

Email _____

Address _____

Student Diagnosis/What qualifies rider for the program _____

Student Age_____ Student Gender _____

Student Ethnicity (*optional – collecting this information helps us with grants*): -Information collected on next page-

Student has IEP plan: ☐ Yes* ☐ No **(If yes please attach a copy of the most current IEP to this packet)*

Primary Method of Contact: ☐ Phone ☐ Email

Student's Riding Goals for 2023:

1.

2.

3.

Additional Rider Information

The collection of this will help us provide additional information for grant funding and will assist with collection of overall statistical data for our organization.

Which county do you reside in?

_____

What is your race or Ethnicity?

Asian ☐
Black or African American ☐
Hispanic or Latino ☐
Middle Eastern or North African ☐
Multiracial or Multiethnic ☐
Native American or Alaska Native ☐
Native Hawaiian or other Pacific Islander ☐
White/Caucasian ☐
Another race or ethnicity_____

Are you or a member of your family a veteran?

No ☐ Yes ☐ If, so who _____

Rider Apparel Sizes

There may be a time that clothing items are given away at no cost to you. Having this information allows us to not have to guess on sizing.

**There will be times where your sizes are collected for specific events for easier accessibility.*

T-Shirt Size _____

Long Sleeve Size _____

Hoodie/Jacket Size _____

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 t**o:

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:_____

New Kingdom Trailriders Medical Release

MEDICAL RELEASE

Name: _____ D.O.B. _____/_____/_____

In my opinion, the individual named above, can participate in supervised equestrian activities. I have reviewed the listed precautions and contraindications. Considering the individual's mental and physical health, the following precautions need to be observed:

_____

_____

MEDICAL HISTORY UPDATE:

Please note any changes in patient's medical history over the year (i.e. major illnesses, surgeries, improvement or deterioration of health).

_____

_____

ADDITIONAL INFORMATION:

(For the safety of our horses, if this information is not completed and initialed by the physician, we reserve the right to refuse services at New Kingdom Trailriders.)

Rider height: _____ Physician initial: _____

Rider weight: _____ Physician initial: _____

Physician's Signature: _____ DATE: _____/_____/_____

Physician's Name: (printed or stamped) _____

Address: _____

City / State / Zip: _____

Telephone: (_____) _____ -_____

PRECAUTIONS

Hip subluxation/dislocation
Scoliosis>30
Osteoporosis
Hydrocephalus/Shunt
Seizure disorders

CONTRAINDICATIONS

Osteogenesis Imperfecta
Atlantoaxial dislocation condition
Total hip arthroplasty
Spinal fusion
Spinal instability
Spinal chord injury above T12

New Kingdom Trailriders

AAI MEDICAL RELEASE

(FOR STUDENTS WITH DOWN SYNDROME ONLY)

Rider Name: _____
Rider D.O.B. _____/_____/_____

I have completed a neurological exam examining for symptoms consistent with atlantoaxial instability (AAI) and focal neurologic disorder.

After completing the neurological exam, the individual named above does not reveal signs of AAI or decrease in neurologic function.

Yes_____ No_____

Comments:

In my opinion, the individual named above may participate in mounted equine activities:
Yes_____ No_____

Additional Information:
(For the safety of our horses, if the height and weight information is not completed and initialed by the physician, we reserve the right to collect this information on-site, at New Kingdom Trailriders. Physician signature required.)

Rider height: _____ Physician initial: _____

Rider weight: _____ Physician initial: _____

*Physician's Signature: _____ DATE: _____/_____/_____

Physician's comments:

Physician's Name: _____

Address: _____

_____

Telephone: (_____) _____ - _____

Mental Health History:

We strive to have an open space here at NKT and invite you
to share some additional information with us, to allow us to better serve you.

_____ I have a personal mental health history. (If initialed, please see below)

_____ I do NOT have a personal history of mental health. (If initialed, please continue to next page)

_____ I would like to disclose information about my mental health history. (If initialed, continue below)

_____ I would NOT like to disclose information about my mental health history. (If initialed, continue to next page.)

Some of my symptoms are:

_____
_____
_____
_____

Some of my triggers are, and my reaction looks like: (mental or physical)

_____
_____
_____
_____

Some of my coping skills are:

_____
_____
_____
_____

Some things I want to work on with my mental health are:

_____
_____
_____
_____

GENERAL LIABIILTY RELEASE: I, _____
(Print participant's Name**)**

Would like to participate in New Kingdom Trailriders' Therapeutic Horseback riding program. I acknowledge the risks and potential for risks of horseback riding and agree to assume all risks of personal injuries and damages regarding involvement in the program. However, I feel that the possible benefits to myself/my son/my daughter/ my ward are greater than the risk assumed. Therefore, in return for being permitted to participate and intending to be legally bound, for myself, my heirs and assigns, executors or administrators, I hereby forever waive and release all claims for damages against New Kingdom Trailriders, its Board of Directors, Property Owners, Sponsors, Instructors, Therapists, Aides, Volunteers, Visitors, Employees, Agents, or others on its behalf liable for any and all injuries and/or losses, I/my son/my daughter/my ward may sustain while participating in the New Kingdom Trailriders therapeutic horseback riding program and agree to indemnify them from all loss, expense, damages and costs they may incur by reason of any claim for damages brought against them. I have read, understand and agree to all of the terms of this liability release and indemnity agreement.

Date: _____ Signature: _____

_____
Parent / Guardian Signature if Participant is under 18

PHOTO RELEASE:

☐ I consent to and authorize the use and reproduction by New Kingdom Trailriders, its advertising agencies, news, radio, and any other persons, of any and all photographs and any other audiovisual materials taken of me/my son/my daughter/my ward, for the promotional printed material, educational activities, exhibitions, newspapers, television, brochures, pamphlets or for any other use for the benefit of the program.

☐ I DO NOT consent to or authorize the use and reproduction by New Kingdom Trailriders, its advertising agencies, news, radio, and any other persons, of any and all photographs and any other audiovisual materials taken of me/my son/my daughter/my ward, for the promotional printed material, educational activities, exhibitions, newspapers, television, brochures, pamphlets or for any other use for the benefit of the program.

Date: _____ Signature: _____

_____
Parent / Guardian Signature if Participant is under 18

EQUINE LIABILITY RELEASE

WARNING:

Under the Equine Activity Liability Act, adopted by the State of Illinois each participant who engages in an equine activity expressly assumes the risks of engaging in and legal responsibility for injury, loss or damage to person or property resulting from the risk of equine activities.

I, _____ **(Print Participant's Name)** would like to participate in New Kingdom Trailriders' therapeutic riding program.
I acknowledge that anyone engaged in this program as a staff member, rider, volunteer or bystander is assuming certain inherent risks that are an integral part of equine activities, including, but not limited to:

(1) The propensity of an equine to behave in ways that may result in injury, harm, or death to persons on or around them.
(2) The unpredictability of an equine's reaction to sounds, sudden movement, and unfamiliar objects, persons, other animals or other things.
(3) Certain hazards such as surface and subsurface conditions.
(4) Collisions with other equines or objects.
(5) The potential of a participant to act in a negligent manner that may contribute to injury to the participant or others, such as failing to maintain control over the animal or not acting within his or her ability.

Each participant who engages in an equine activity expressly assumes the risk of and legal responsibility for injury, loss or damage to the participant or the participant's property that results from participating in an equine activity.
Having read and understood the above description of the liability of equine activities, I agree to release New Kingdom Trailriders, its staff, volunteers, committees or board members from any liability except where negligence can be proven.

Date _____ Signature: _____
(Parent or guardian's signature if participant is under 18 years old)

New Kingdom Trailriders
Policies and Procedures Agreement

I, _____ have received and read the NKT Rider Handbook. By initialing below, I indicate that I understand and agree with these NKT policies:

Please initial:

_____ Rider Eligibility

_____ Lesson Fees and Payment

_____ Absence Policy

_____ Lesson Cancellations

_____ Financial Assistance/Scholarships

_____ Riding Schedule/Lesson Availability

_____ Lesson Description

_____ Clothing Requirements for Riders

_____ Rider/Parent/Caregiver Responsibilities

_____ Refusal Policy

_____ Parental/Caregiver Participation

_____ Rider Opportunities

_____ Barn Rules

_____ Communication

Signed:_____

Print: _____ Date: _____