Centaur Stride, INC
A therapeutic horseback riding center

FIELD TRIP RIDER REGISTRATION

Client: _____ Date of Birth: _____ Gender: _____
Height: _____ Weight: _____
Residence address:_____City: _____ State: _____
School Attending (if applicable):_____
Parent/Legal Guardian (if applicable): _____
Phone: _____

Authorization for Emergency Medical Treatment
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, I authorize Centaur Stride staff to:
1. Activate Emergency Medical Services, Provide First Aid, or CPR.
2. Release copies of client records to the authorized medical individuals involved in the emergency.
Emergency Contact: _____ Phone: _____
Client Family Physician Name: _____ Phone: _____
Health Insurance Company: _____Policy#_____

Check one of the following options:

- o **Option 1, Consent Plan:**
  This authorization includes xray, surgery, hospitalization, medication, and any treatment procedures deemed "life saving" by the physician. This provision will only be invoked if the consenting person listed above is unable to be reached.

OR

- o **Option 2, Non-Consent Plan**:
  I do not give my consent for emergency medical treatment/aid in the case of illness or injury. In the event emergency treatment/aid is required, I wish the following procedures to take place:
  _____

** A copy of DNR must be provided if non-consent is requested.

Medical History/Physician Release Any conditions, physical, cognitive, or emotional, need to be made known in writing to instructors prior to riding, in order for Centaur Stride staff to be able to take all accounts into consideration for a **safe riding** program.
Please complete this form as thoroughly as possible. For items that are not applicable, please write N/A.

Please list and explain any major illness/injuries:
_____
_____

Any known allergies to**:** Yes ☐ No ☐ If Yes please specify:
_____

Medical Diagnosis: _____

Please indicate if client has a problem and/or surgeries in any of the following areas by checking yes or no. If yes, please comment.

Areas	Yes	No	Comments/Date of Surgery
Auditory			
Visual			
Speech			
Cardiac			
Circulatory			
Pulmonary/Asthma			
Neurological			
Muscular/Orthopedic			
Epilepsy/seizures			
Diabetes			
Atlanto-axial instability*			
Cognitive Impairment			
Psychological Impairment			
Epilepsy/seizures			

**Down's Syndrome – Must have negative X-ray and MD signature on physician release form to ride*.

Other Mobility: ( ) Independent Ambulation ( ) Crutches ( ) Braces ( ) Wheelchair
Please Indicate Any Special Precautions or Restrictions:

_____

As legal guardian, I verify that the information disclosed above is thorough and accurate. I further verify that I will inform Centaur Stride, Inc. of any physical or medical changes/concerns.

Liability Release and Express Assumption of Risk

-ACKNOWLEDGE THAT HORSEBACK RIDING IS AN INHERENTLY DANGEROUS ACTIVITY AND INVOLVES RISKS THAT MAY CAUSE SERIOUS INJURY AND IN SOME CASES DEATH, because of the unpredictable nature and irrational behavior of horses, regardless of their training and past performance. I acknowledge and accept that horseback riding, ground work, and activities around the horses involve the risk of personal injury. By my signature (and in the case of a minor, the parent's or guardian's signature), they and I hereby waive all rights, if any, claims, causes of action and lawsuits against Centaur Stride, Inc., property owners, executors, legal representatives, administrators, successors, assigns, guests, employees, board members, or agents affiliated with any of them in any manner for any injury, liability or damages that may occur while riding any horse, whether leased or owned by Centaur Stride, or for any injury or damages that may occur while participating in **any activity** related to horseback riding.
-I agree to indemnify, defend, and hold harmless Centaur Stride, Inc. or any person or entity whose land a horseback ride crosses for any accident, injury or loss that might occur, and free such persons from all liability for such injury or loss.
-I am aware that wearing a certified safety helmet is a good preventative measure against head injury and further understand that helmets are required for all riders. Helmets have been provided.

Photo Release: I hereby grant the *Centaur Stride, Inc.* permission to use my likeness or that of my minor child in a photograph, video, or other digital media ("photo") in any and all of its publications, including web-based publications, advertisements, or for educational purposes. I hereby irrevocably authorize Centaur Stride, Inc. to edit, alter, copy, exhibit, publish, or distribute these photos for any lawful purpose.

I have read and fully understand this liability release. My signature below constitutes acceptance of the above terms and conditions and acknowledgement that I (or my child) have <u>no physical limitations or pre-existing conditions</u> that would impede my (their) ability to ride a horse. Any conditions, physical, cognitive, or emotional, need to be made known in writing to instructors prior to riding, in order for CS staff to be able to take all accounts into consideration for a safe riding program. *(A separate registration form is available for any pre-existing conditions or limitations.)*

_____
Print Name of Client (Include client's age if minor)

Signature(Client or parent/guardian if minor/dependent): _____

If not client signature above, specify relationship to client: _____ Date_____

Client Address: _____

_____ _____
Email (parent's if minor) Phone number

A Physician's Release is required for any rider with any known physical or cognitive/emotional impairments that require any special handling or therapeutic interventions requiring a therapist, or for medical clearance after any injury or surgery. Instructors are trained in working with special needs populations to modify horseback riding programs and training of therapy horses. They are not therapists.
Riders requiring a therapist will be placed on a waiting list for when a therapist is available to evaluate the client and train staff in special handling skills or work directly with the client.

Rider Name: _____ Phone: _____

Address: _____

Physician's Certification: In my opinion this patient can participate in equestrian activities.
I certify that I have examined the above individual and I feel this individual may participate in Centaur Stride programs, horseback riding, and/or physical activities, except the following:

_____
_____
_____
_____
_____

_____ _____
Name of examining physician(Please print)

_____
_____
Signature of examining physician Date

_____
_____
Address of examining physician(please print) Phone

Last updated: 3/2025