

## **FIELD TRIP RIDER REGISTRATION**

Client: _		Date of Birth:	Gender:		
Height:	Weight:				
Residen	ice address:	City:	State:		
School A	Attending (if applicable):				
Parent/	Legal Guardian (if applicable):				
Phone:					
	zation for Emergency Medical Treatment				
	vent emergency medical aid/treatment is	•			
	ig services, or while being on the property		iff to:		
	ate Emergency Medical Services, Provide F	•			
	ise copies of client records to the authorize		- ·		
	ncy Contact:				
	amily Physician Name:				
Health I	nsurance Company:	Policy#			
Check o	one of the following options:				
0	Option 1, Consent Plan:				
	This authorization includes xray, surgery, l	•	•		
	procedures deemed "life saving" by the p	•	nly be invoked if the		
	consenting person listed above is unable	to be reached.			
OR					
0	Option 2, Non-Consent Plan:				
0	I do not give my consent for emergency m	adical treatment /aid in the co	oco of illnoss or injury In		
	the event emergency treatment/aid is rec				
	the event emergency treatment/aid is rec	fulled, I wish the following pro	icedures to take place.		
** A CO	py of DNR must be provided if non-consen	t is requested			
7 00	py of Divit must be provided if non-consen	t is requested.			
Medica	I History/Physician Release Any condition	s. physical, cognitive, or emot	ional, need to be made		
	in writing to instructors prior to riding, in o				
	accounts into consideration for a <b>safe riding</b> program.				
Please complete this form as thoroughly as possible. For items that are not applicable, please write N/A.					
i icase c	somplete this form as thoroughly as possit	inc. For items that are not app	neadle, piease write 11,7 t.		
Please I	ist and explain any major illness/injuries:				
· ·cuse ·	ist and explain any major infess, injuries.				
Any kno	own allergies to: Yes 🔲 No 🔲 If	Yes please specify:			
,		, , , , , , , , , , , , , , , , , , ,			
Medica	l 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			

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

Other Mobility: ( ) Independent Ambulation Please Indicate Any Special Precautions or Restri	` '	( ) Braces	( ) Wheelchair	

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.

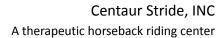
-I agree to indemnify, defend, and hold harmless Centaur Stride, Inc. or any person or entity whose land a horseback ride crosses for any accident, injury or loss that might occur, and free such persons from all liability for such injury or loss.
-I am aware that wearing a certified safety helmet is 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 no physical limitations or pre-existing conditions 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	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:		
I certify that I have examined the above Stride programs, horseback riding, and/o	ion this patient can participate in equestrian activities individual and I feel this individual may participate i or physical activities, except the following:	in Centau
Name of examining physician (Please pr	int)	
Signature of examining physician	 Date	
Address of examining physician (please)	print) Phone	

Last updated: 3/2025