Checked and Ap	pproved by:
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IF SIGNATURES ARE TYPED:

I am checking this box and agree that my typed signature serves as my handwritten signature for all forms included in this packet.

Date:
Rider Check List
Chimp Mail
Rider Contact
Rider Emergency
Quickbooks
Equiforce
Scanned
Attached
Master Mailing List
Ready to be Filed
Staff use only

Rider Name:		
Rider Age:		Rider Gender:
Rider Height:'	,,	Rider Weight: lbs
Rider has IEP plan:	Yes*	No *(If yes please attach a copy of the most current IEP or BIP to this packet)
Rider Diagnosis/What qu	alifies this	student to be a rider at NKT:

Rider's Riding Goals for 2025 (What rider wants to learn/work on):

1.

2.

3.

I have read the 2025 NKT Riders Handbook. By signing below, I indicate that I understand and agree with NKT policies: **Updates have been made to the 2025 Handbook be sure to read**

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

****If no additional information has changed since the completion of the 2024 forms, you may skip pages 3 & 4.

Initial here that no additional information has changed & forms are complete

New Kingdom Trailriders Authorization for Emergency Medical Treatment Form

	Participant	Staff	Volunteer		
Name:			DOB:	Phone:	
Address:					
Street		city		State	zip
Physician's Name	e:		Preferre	d Medical Facility	
Health Insurance	Co:		Policy	#:	
Allergies to medi	cations:				
Current medication	ons:				
Medical Conditio	ons/Special Accommodat	ions Needed:			
	an emergency, conta				
					one:
					one:
Name:			Relation:	Ph	one:
	nergency medical aid/treaterty of the agency, I auth			during the process of	f receiving services, or while
	ure and retain medical tre ease client records upon			ncy involved in the	medical emergency treatment
Consent Plan		1			
This authorization		-	, medication and any treat on(s) above is unable to be	-	ned "life saving" by the
Date:	Consent S	ignature:			
		·	Client, Parent or Leg	al Guardian	
Non Concert Die		nedical treatmen	t/aid in the case of illness	or injury during the	process of receiving services
do not give my o	consent for emergency m e property of the agency				
while being on the	e property of the agency at or legal guardian will r	emain on site at	all times during equine as ed, I wish the following p		ce.

Date

NKT – RIDER REGISTRATION FORM UPDATE – 2025

Rider Name	:			
Rider Conta	ct information:			
Pref	erred method of contact:	Phone	Email	
Prin	nary Contact (Self/Parent/Gua	rdian):		
Nam	1e:			
Rela	tionship to Student or Self:			
	ondary Contact (Self/Parent/G	,		
Add	ress:			

*If there is an additional information you need to update it is your responsibility to email Monika at Monika@nktriders.org