

Vet Check Letter

Date: _____

Horses' Name: _____

Owners Name: _____

Date of last dental exam/float: _____

Date of last shots given and type: _____

Date of last dewormer given and type: _____

To be completed by licensed veterinarian only:

Horses Weight: _____

Horses Height: _____

Horses Age: _____

Comments on:

Eyes: _____

Back: _____

Legs/Hooves: _____

Teeth: _____

Overall Condition: _____

How long have you known this horse? _____

To the best of your judgment, do you believe that this horse would be suitable for a therapeutic riding/hippotherapy program at Horses Help? *Although we are a therapeutic riding program, all of our horses must sound at the walk and trot, in good health, be able to comfortably carry 15-20% of their weight, and be able to do moderate work 3-5 days a week.*

Veterinarian's Name (printed): _____ Practice: _____

Signed: _____ Date: _____

Phone Number: _____