



# Personal Ponies

u p d a t e d J u n e 2 0 2 1

## Personal Ponies Yearly HEALTH CARE FORM

Please return this form, completed & signed by your vet, a copy of the current coggins certificate & close up photos from each side **by June 1 each year** to:

Cindy Pullen National Director  
368 River Rd.  
Lakeland, GA 31635

Failure to comply may result in removal of pony.

Date: \_\_\_\_\_  
Organization or /Lessee Name: \_\_\_\_\_

Best Contact Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
Address: \_\_\_\_\_

**Note:** if location of ponies is different from above address, also provide pony location:  
Address: \_\_\_\_\_

Pony location contact name & phone \_\_\_\_\_

Email \_\_\_\_\_ Phone Cell: ( ) \_\_\_\_\_

Pony name : \_\_\_\_\_

Microchip#: \_\_\_\_\_  
(Please scan to verify correct number if necessary)

Sex: Gelding \_\_\_\_\_ Mare \_\_\_\_\_

Date of Birth \_\_\_\_\_

HEALTH EXAM - To be completed & signed by your vet. Please check one

Comment below

EYES:	Good _____	Fair _____	Poor _____
WEIGHT:	Good _____	Fair _____	Poor _____
HOOF CONDITION:	Good _____	Fair _____	Poor _____
COAT CONDITION:	Good: _____	Fair: _____	Poor: _____
RESPIRATION:	Good: _____	Fair: _____	Poor: _____
HOUSING/FACILITIES:	Good: _____	Fair: _____	Poor: _____

GELDING SHEATH CLEANING DONE: Yes \_\_\_\_\_ No \_\_\_\_\_

COMMENTS ON ANY CONDITIONS NOTED: use back if necessary

**Please describe all illnesses, injuries, lameness or conditions that have occurred **over the past year**. Be sure to include dates and detail about length, treatment/procedures and resolution. This is important so we can update their health records in our database for future reference. Include any ongoing medication. Use back of form if necessary.**

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DENTAL CARE: Yes \_\_\_ No \_\_\_ If yes, DATE & please describe \_\_\_\_\_

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ANNUAL VACCINATIONS [To be kept current per your area vet recommendation]

Type \_\_\_\_\_ Date Given \_\_\_\_\_

Type \_\_\_\_\_ Date Given \_\_\_\_\_

Type \_\_\_\_\_ Date Given \_\_\_\_\_

Type \_\_\_\_\_ Date Given \_\_\_\_\_

Type \_\_\_\_\_ Date Given \_\_\_\_\_

COGGINS CERTIFICATE [Annual to be kept current]

Date Tested: \_\_\_\_\_ Results: \_\_\_\_\_ Attach copy

VET SIGNATURE: \_\_\_\_\_ Date: \_\_\_\_\_

NAME OF PRACTICE/CLINIC: \_\_\_\_\_

Address: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone#: (\_\_\_\_) \_\_\_\_\_ Fax(\_\_\_\_) \_\_\_\_\_

Email \_\_\_\_\_

**This portion to be completed by caregiver:**

Date Deworming or fecal count      Product Used      Results/comments

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Farrier Dates      Work done      Comments

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**Note:** This form shall serve to establish Personal Ponies Ltd. as legal owner of this pony, as well as a medical release form granting permission for this vet, farrier, practitioner and/or a member of his/her staff, to provide medical information regarding this pony to Personal Ponies Ltd. or a representative thereof, upon verbal or written request. Please insure your providers understand and will release info.

Caregiver's Agreement Signature \_\_\_\_\_ Date \_\_\_\_\_