



DISTRICT (5) 4-H HORSE CAMP VETERINARIAN TREATMENT AUTHORIZATION

HORSE OWNER'S NAME: _____

ADDRESS: _____
(STREET)

(CITY) (STATE) (ZIP)

PHONE: () _____

Please indicate your horse's last vaccination dates for the following:

Tetanus: _____ **Eastern/Western Encephalitis:** _____

Rabies: _____ **Potomac Horse Fever:** _____

Influenza: _____

List existing conditions vet may need to know:

.....
PARENT'S NAME: _____

ADDRESS: _____
(STREET)

(CITY) (STATE) (ZIP)

PHONE: () _____ **EMERGENCY PHONE:** () _____

.....
PREFERRED VET: _____ **PHONE:** () _____

I understand that should my child's horse be injured that I will be notified, but if I cannot be reached by telephone, it is my understanding that our veterinarian will be called to render proper medical treatment. If they cannot be reached another local vet will be called. In doing so I also agree to be totally responsible for any charges that may be incurred.

SIGNED