MEDICAL CLEARANCE FOR EQUESTRIAN SPORTS

Date: [Date]

Patient Name: [Patient Full Name]
Date of Birth: [Patient DOB]

To Whom It May Concern,

I have examined the above-named patient on [Date of Examination]. Based on my clinical evaluation, I find the patient to be in good physical and mental health and free from any medical condition that would preclude their participation in equestrian activities.

The patient is cleared for the following (check all that apply):
[ ] General horseback riding and instruction
[ ] Competitive horse shows / events
[ ] Jumping activities
[ ] Full contact/High-intensity equestrian sports

Limitations or Restrictions:
[List any restrictions or "None"]

Medications:
[List any medications that may affect balance or alertness, or "None"]

This clearance is valid until [Expiration Date]. Should the patient's medical status change significantly, a re-evaluation will be required.

Sincerely,

Physician Name: [Name and Title]
Medical License Number: [License #]
Clinic/Hospital Name: [Facility Name]
Phone Number: [Phone Number]

Signature: _____