DRESSAGE COMPETITION MEDICAL CLEARANCE FORM

Date: [Insert Date]

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

To the Competition Secretary / Organizing Committee,

I hereby certify that I have examined the above-named patient and reviewed their medical history. Based on my evaluation, I find them to be physically and mentally fit to participate in equestrian dressage competitions.

This clearance confirms that the patient is capable of:

- Maintaining the physical balance and core strength required for dressage riding.
- Mounting and dismounting a horse independently (unless otherwise noted for para-equestrian categories).
- Exerting the cardiovascular effort required for competitive riding tests.
- Managing the cognitive demands and safety requirements of being around horses.

Medical Restrictions (if any): [Insert "None" or specify restrictions]

Medications: [Insert any medications that may affect performance or safety, or state "None"]

This clearance is valid until: [Insert Expiration Date]

Physician Name: [Insert Name and Title]

Medical License Number: [Insert License Number]

Facility Name: [Insert Clinic/Hospital Name]

Phone Number: [Insert Phone Number]

Signature: _____

Official Stamp: