**Equine Health and Vaccination Record**

Note: this is **not a vaccination certificate** or a proof of vaccination. This is an owner / custodian record. A certificate of vaccination would require a veterinary practitioner signature and details.

This record is a fillable, printable Word document.

|  |  |
| --- | --- |
| Owner:      | Phone(s):       |
| Address:       |
| Equine Name:       |
| Sire:       | Dam:       | Sex:      |
| Breed:       | Weight:      | Height:      |
| Birth Date:       | Tattoo:      | Microchip number:       |
| Markings:      | Photos available [ ]  Yes [ ]  No |
| Breed Registry / Number:      |
| Comments:      |
| **Vaccination Record** |  | **Deworming Record** |
| **Rhinopneumonitis (EHV-1/4)**  | **Equine Herpes Virus 1 (abortion)** | **Influenza A1 and A2** | **E & W Encephalomyelitis** | **Tetanus** | **Potomac Horse Fever** | **Strangles** | **Rabies** | **West Nile** | **Other** | **Age/Date** |  | **Product** | **Deworming** | **Fecal Exam** | **Date/Year** |
| [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |       |  |       | [ ]  | [ ]  |       |
| [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |       |  |       | [ ]  | [ ]  |       |
| [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |       |  |       | [ ]  | [ ]  |       |
| [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |       |  |       | [ ]  | [ ]  |       |
| [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |       |  |       | [ ]  | [ ]  |       |
| [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |       |  |       | [ ]  | [ ]  |       |
| [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |       |  |       | [ ]  | [ ]  |       |
| [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |       |  |       | [ ]  | [ ]  |       |
| [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |       |  |       | [ ]  | [ ]  |       |
| [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |       |  |       | [ ]  | [ ]  |       |
| [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |       |  |       | [ ]  | [ ]  |       |
| [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |       |  |       | [ ]  | [ ]  |       |
| [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |       |  |       | [ ]  | [ ]  |       |
| [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |       |  |       | [ ]  | [ ]  |       |
| **Notes (including an adverse reactions):** |  | **Notes:** |

I = Initial vaccination

B = Booster vaccination

|  |  |  |
| --- | --- | --- |
| **Medical Record** |  | **Hoof Care** |
| **Date** | **Comments** |  | **Date** | **Comments** |
|       |       |  |       |       |
|       |       |  |       |       |
|       |       |  |       |       |
|       |       |  |       |       |
|       |       |  |       |       |
|       |       |  |       |       |
|       |       |  |       |       |
|       |       |  |       |       |
|       |       |  |       |       |
|       |       |  |       |       |
|       |       |  |       |       |
|       |       |  |       |       |
|       |       |  |       |       |
|       |       |  |       |       |
|       |       |  |       |       |
|       |       |  |       |       |
|       |       |  |       |       |
|       |       |  |       |       |
|       |       |  |       |       |
|       |       |  |       |       |
|       |       |  |       |       |
|       |       |  |       |       |
|       |       |  |       |       |
|       |       |  |       |       |
|       |       |  |       |       |
|       |       |  |       |       |
|       |       |  |       |       |
|       |       |  |       |       |
|       |       |  |       |       |
|       |       |  |       |       |

|  |  |  |
| --- | --- | --- |
| **Coggins Test** |  | **Dental Care** |
| **Date** | **Comments** |  | **Date** | **Comments** |
|       |       |  |       |       |
|       |       |  |       |       |
|       |       |  |       |       |
|       |       |  |       |       |
|       |       |  |       |       |
|       |       |  |       |       |
|       |       |  |       |       |
|       |       |  |       |       |
|       |       |  |       |       |
|       |       |  |       |       |
|       |       |  |       |       |
|       |       |  |       |       |
|       |       |  |       |       |
|       |       |  |       |       |
|       |       |  |       |       |
|       |       |  |       |       |
|       |       |  |       |       |
|       |       |  |       |       |
|       |       |  |       |       |
|       |       |  |       |       |
|       |       |  |       |       |
|       |       |  |       |       |
|       |       |  |       |       |
|       |       |  |       |       |
|       |       |  |       |       |
|       |       |  |       |       |
|       |       |  |       |       |
|       |       |  |       |       |
|       |       |  |       |       |
|       |       |  |       |       |