

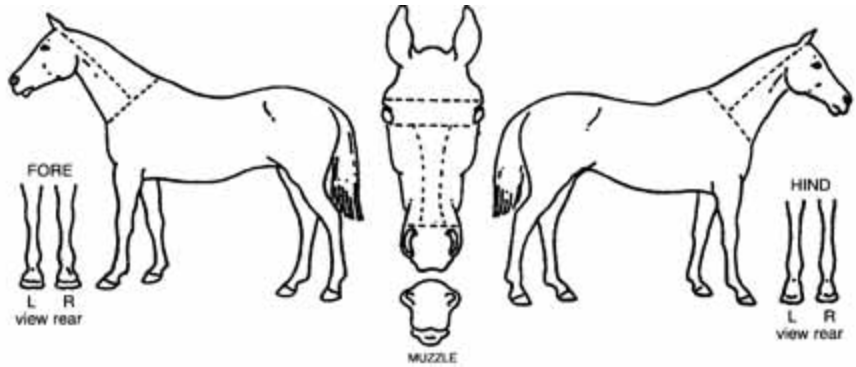
FOAL VETERINARY CERTIFICATE FOR MORTALITY INSURANCE For horses aged between 24 hours and 45 days only

Owner and Address (if known) _____
 Animal presented as _____ Breed _____
 If Animal Unnamed: Sire _____ Dam: _____
 Colour _____ Age: _____ (days) Sex: _____
 Person requesting examination _____
 Place of examination: _____

Do you normally attend this property? Yes No

Draw Markings:

Mark whorls as X,
Scars as →



Section 1

- | | |
|---|--|
| <p>1. Is the foal's appearance and behaviour consistent with normal gestation and parturition? _____ Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>2. Does the mare allow the foal to nurse without being restrained? _____ Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>3. Is the foal able to get up and down and nurse on its own? _____ Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>4. Does the foal show clinical evidence of colic? _____ Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>5. Has milk been observed at the nostrils following suckling? _____ Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>6. Is severe parrot mouth present? _____ Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>7. Is there evidence of congenital cataracts or other abnormalities of the eyes? _____ Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>8. Does the foal have significant flexor or angular limb deformities? _____ Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>9. Is there evidence of rib fracture? _____ Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>10. Is the umbilicus dry and normal? _____ Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>11. Does the foal have a patent urachus? _____ Yes <input type="checkbox"/> No <input type="checkbox"/></p> | <p>12. Is there evidence of umbilical or inguinal hernia? _____ Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>13. Is there clinical evidence of diarrhoea? _____ Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>14. Is there clinical evidence of retained meconium? _____ Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>15. Is the heart normal on auscultation? _____ Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>16. Are the lungs normal on auscultation? _____ Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>17. Is the gastro-intestinal tract normal on auscultation? _____ Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>18. Is there clinical evidence of ataxia or lameness? _____ Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>19. Is the temperature normal? _____ Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>20. Is the pulse rate normal? _____ Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>21. Is the respiratory rate normal? _____ Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>22. Has a haemogram been performed? _____ Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>23. If yes to 22 above, are all readings within normal limits? _____ Yes <input type="checkbox"/> No <input type="checkbox"/></p> |
|---|--|

I have today performed a clinical examination on this horse in accordance with AEVA Insurance guidelines, and declare that to the best of my professional knowledge the horse is clinically normal and in a satisfactory condition, except as noted.

Section 2

1. What medication has the foal received post partum? _____
2. IgG Test. Where multiple tests have been done, dates, times and results of all tests must be recorded.

| Time after birth | Level | Performed by Stud/Lab/Vet |
|------------------|-------|---------------------------|
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| | | |

3. Has a colostrum supplement been given to the foal and if so, when? _____
4. Has plasma been given to the foal and if so, when? _____
5. Is a nurse mare being used for this foal and if so, has the nurse mare accepted the foal? _____

Date and time of examination: _____ Signature: _____

Signed:
 Veterinary Surgeon (print):
 AVA Member No:
 Date: Time:

Practice Name, address, telephone no: