Medical Consent Form

Date:_____

Dear Doctor,

Your patient, _____, wishes to participate in a therapeutic program at Karin's Horse Connection at Legacy Stables. This program will include doing various 'work' tasks around the stables and interacting with horses, including riding. Please note any conditions which may require precautions and/or contraindications to the patient's participation in the program. Including, but not limited to: allergies, history of seizures, and behavioral issues.

_____
_____
_____
_____

If you feel the patient is able to participate in this program, please provide your signature.

Thank you,

Karin Schmidt
Legacy Stables
Karin's Horse Connection
8001 Patterson SE
Caledonia, MI 49316
Personal: 616-498-7028
Business: 616-570-1106

Physician Signature_____