

CALF ABNORMALITY REPORT

Herd Owner: _____ Prefix: _____

Address: _____ Phone: _____

Birth date: _____		Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Animal was born: <input type="checkbox"/> Stillborn <input type="checkbox"/> Alive but died _____ days later <input type="checkbox"/> Living			
Single or multiple: <input type="checkbox"/> Single <input type="checkbox"/> Twin <input type="checkbox"/> Triplet or higher			
Ease of calving: <input type="checkbox"/> Normal <input type="checkbox"/> Malpresentation <input type="checkbox"/> Difficult <input type="checkbox"/> Surgery <input type="checkbox"/> Traction			
Name of Dam: _____		Registration No. _____	
Dam's Sire _____		Registration No. _____	
Latest breeding that resulted in this offspring:			
Date	ET	Sire Name	Registration No.
Last Service: _____ <input type="checkbox"/>		_____	
Prior Service: _____ <input type="checkbox"/>		_____	

Did a Veterinarian attend to this animal? Yes No

Veterinarian: _____ Address: _____

Describe abnormal condition being reported (in own words) _____

Please check (✓) any abnormal conditions that may apply:

Body If not listed below, please specify: _____

<input type="checkbox"/> Appearance	<input type="checkbox"/> Weak <input type="checkbox"/> Dwarf <input type="checkbox"/> Mummified <input type="checkbox"/> Internal organs outside <input type="checkbox"/> Bulldog
<input type="checkbox"/> Muscles & Bones	<input type="checkbox"/> Uncoordinated <input type="checkbox"/> Spasm <input type="checkbox"/> Missing muscles <input type="checkbox"/> Contracted muscles <input type="checkbox"/> Missing bones
<input type="checkbox"/> Hide & Hair	<input type="checkbox"/> Hairless <input type="checkbox"/> Abnormal skin development <input type="checkbox"/> Albino
<input type="checkbox"/> Abdomen	<input type="checkbox"/> Umbilical hernia

Head If not listed below, please specify: _____

<input type="checkbox"/> Size & Shape	<input type="checkbox"/> Enlarged <input type="checkbox"/> Small <input type="checkbox"/> Wide forehead <input type="checkbox"/> Depression between eyes <input type="checkbox"/> Bulging forehead
	<input type="checkbox"/> Opening in forehead <input type="checkbox"/> Narrow Muzzle
<input type="checkbox"/> Eyes	<input type="checkbox"/> Closed <input type="checkbox"/> Small eye <input type="checkbox"/> No eyeballs <input type="checkbox"/> Pop eyes <input type="checkbox"/> Crossed eyes <input type="checkbox"/> Blind
	<input type="checkbox"/> Hairs in eye <input type="checkbox"/> Film over eye <input type="checkbox"/> Sunken eyes
<input type="checkbox"/> Nose	<input type="checkbox"/> Fused nostrils <input type="checkbox"/> Pug nose <input type="checkbox"/> Wry face <input type="checkbox"/> Double
<input type="checkbox"/> Lower Jaw	<input type="checkbox"/> Won't open <input type="checkbox"/> Short <input type="checkbox"/> Long <input type="checkbox"/> Impacted molars <input type="checkbox"/> Absent
<input type="checkbox"/> Upper Jaw	<input type="checkbox"/> Cleft palate <input type="checkbox"/> Short <input type="checkbox"/> Long <input type="checkbox"/> Absent

Feet & Legs If not listed below, please specify: _____

<input type="checkbox"/> Limbs	<input type="checkbox"/> Absent <input type="checkbox"/> Crossed <input type="checkbox"/> Short <input type="checkbox"/> Paralyzed <input type="checkbox"/> Extra limbs <input type="checkbox"/> Crooked
	<input type="checkbox"/> Contracted flexor tendons <input type="checkbox"/> Permanent joint contracture <input type="checkbox"/> Missing dew claw
<input type="checkbox"/> Feet	<input type="checkbox"/> Extra feet <input type="checkbox"/> One toe <input type="checkbox"/> Extra toe <input type="checkbox"/> Feet turned back

Rump If not listed below, please specify: _____

<input type="checkbox"/> Loin & Tail	<input type="checkbox"/> Short/missing vertebrae <input type="checkbox"/> No tail <input type="checkbox"/> Short tail <input type="checkbox"/> Crooked tailhead <input type="checkbox"/> Extra tail
<input type="checkbox"/> Rectum-Vagina	<input type="checkbox"/> High <input type="checkbox"/> Common opening <input type="checkbox"/> No anus <input type="checkbox"/> Missing or abnormal sexual organs

Return to: Ayrshire Canada, 4865, boul. Laurier O, St-Hyacinthe, Qc, J2S 3V4 Fax: 450-778-3531