MEDICATION REPORT FORM

UNITED STATES EQUESTRIAN FEDERATION - ALL THINGS EQUESTRIAN

A. IDENTIFICATION OF HORSE/ PONY (PLEASE TYPE, PRINT, OR WRITE CLEARLY)

1. Name:		
2. Age:	3. Sex:	4. Color:
5. Weight:	6. Entry Number:	
7. Trainer's Name:		
8. Owner's Name:		
9. Breed/Discipline in which the animal competes:		

B. IDENTIFICATION OF MEDICATION (PLEASE TYPE, PRINT, OR WRITE CLEARLY)

10. Product Name:		
11. Amount Administered:	Strength:	
12. Route of Administration: ❑ Oral ❑ Topical	❑ Injectable ❑ Intravenous ❑ Intramuscular ❑ Subcutaneous ❑ Intra-articular	❑ Inhalation
13. Date of Administration:		
14. Time of Last Administration: _____:_____ ❑ a.m. ❑ p.m.		
15. Diagnosis and Reason for Administration (This must be for a Therapeutic Purpose only):		
16. Name of Veterinarian Prescribing/Administering the Medication:		
17. Phone Number of Prescribing Veterinarian:		
18. Name and Signature of Person Administering the Medication: Print:	Sign:	

C. INSTRUCTIONS TO STEWARDS/ TD OR DESIGNATED SHOW OFFICE REPRESENTATIVE (PLEASE TYPE, PRINT, OR WRITE CLEARLY)

IMPORTANT: You should accept this form only after all blanks above have been completed. Incomplete forms must be returned immediately to the owner/trainer for completion. Please note whether a specific diagnosis is recorded in section 15 above.

If all blanks are completed, please indicate the following:		
Date Received:	Time Received:	❑ a.m. ❑ p.m.
Name of Show/Event:	Date(s) Held:	
City and State:		
Name and Signature of Steward/TD or Designated Show Office Representative; Mark One ❑ Steward/TD ❑ DSOR		
Print:	Sign:	

Please call (800) 633-2472 if you have any questions about the Equine Drugs and Medications Rule.

WHITE - USEF YELLOW - STEWARD/TD PINK - OWNER/TRAINER

Return to: United States Equestrian Federation, Inc.

Equine Drugs and Medications Program • 956 King Avenue • Columbus, OH 43212-2655