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:  8. IDENTIFICATION OF MEDICATION (PLEASE TYPE, PRINT, OR WRITE CLEARLY)  10. Product Name:  11. Amount Administration:   Oral   Topical   Injectable   Intravenous   Inhalation   Intra-articular  12. Route of Administration:   Oral   D.m.  13. Date of Administration:   a.m. D.m.  14. Time of Last Administration:   a.m. D.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:  17. Phone Number of Person Administering the Medication:  18. Name and Signature of Person Administering the Medication:  19. INSTRUCTIONS TO STEWARDS/ TO 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.	A. IDENTIFICATION OF HORSE/ PONY (PLEASE TYPE, PRINT, OR WRITE CLEARLY)					
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: 12, Route of Administration: 13, Date of Administration: 14, Time of Last Administration: 14, Time of Last Administration: 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 Administrating 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/frainer for completion, Please note whether a specific diagnosis is recorded in section 15 above.	1. Name:					
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:   Intravenous   Intra	2. Age:	3. Sex:	4. Color:			
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:  12. Route of Administration:    Oral	5. Weight:	6. Entry Number:				
B. IDENTIFICATION OF MEDICATION (PLEASE TYPE, PRINT, OR WRITE CLEARLY)  10. Product Name:  11. Amount Administered:  12. Route of Administration:	7. Trainer's Name:					
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   Inhalation   Intra-articular  13. Date of Administration:   a.m.   p.m.  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.	8. Owner's Name:					
10. Product Name:  11. Amount Administered:  12. Route of Administration:  13. Date of Administration:  14. Time of Last Administration:  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.	9. Breed/Discipline in which the animal competes:					
11. Amount Administered:  12. Route of Administration:	B. IDENTIFICATION OF MEDICATION (PLEASE TYPE, PRINT, OR WRITE CLEARLY)					
12. Route of Administration:	10. Product Name:					
Intramuscular   Subcutaneous   Intra-articular	11. Amount Administered:		Strength:			
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.	12. Route of Administration:   Ora	al 🗖 Topical	□ Injectable	<ul><li>☐ Intramuscular</li><li>☐ Subcutaneous</li></ul>	☐ Inhalation	
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.	13. Date of Administration:					
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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.	17. Phone Number of Prescribing Veterinarian:					
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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.	C. INSTRUCTIONS TO STEWARDS/ TD OR DESIGNATED SHOW OFFICE REPRESENTATIVE (PLEASE TYPE, PRINT, OR WRITE CLEARLY)					
If all blanks are completed, please indicate the following:						
	If all blanks are completed, please indicate the following:					
Date Received: ☐ a.m. ☐ p.m.	Date Received:	Time Received:	□ a	m. □ p.m.		
Name of Show/Event: Date(s) Held:	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

Return to: United States Equestrian Federation, Inc.

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

PINK - OWNER/TRAINER