MEDICATION REPORT FORM

(Last Updated 11/5/2015)

A. IDENTIFICATION OF HORSE *(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:_____

B. IDENTIFICATION OF MEDICATION *(Please type, print, or write clearly)*

10. Product Name: _____
11. Amount Administered:_____ Strength:_____
12. Route of Administration *(Please check one)*:

    ❒ Oral ❒ Topical ❒ Injectable *(Please check one)*:

    ❒ Intravenous ❒ Inhalation ❒ Intramuscular

    ❒ Subcutaneous ❒ Intra-articular
13. Date of Administration:_____
14. Time of Last Administration: ____ : ____ a.m. or p.m. *(Please circle one)*
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 SHOW STEWARD/REP 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. or p.m. *(Please circle one)*

Name of Show/Event: _____ Date(s) Held: _____

City and State: _____

Name and Signature of Show Steward/Representative or Designated Show Office Representative:

(Please check one): ❒ Show Steward/Rep ❒ Designated Show Office Representative

Print:_____ Sign: _____