



MEDICATION REPORT FORM

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: _____