MEDICATION REPORT FORM

Please type, print, or write clearly. A digital version of the form is available on nrha.com/welfare.

SECTION A, D & E: MUST BE COMPLETED.
SECTION B & C: EACH SECTION MUST BE COMPLETED IF THOSE MEDICATIONS WERE ADMINISTERED.
**If medication is being administered by anyone other than the prescribing veterinarian, please include a copy of the Rx.*

Please review this form carefully and sign that all information is correct.

A. IDENTIFICATION OF HORSE

1. Name: _____
2. Age: _____ 3. Sex: _____ 4. Color: _____ 5. Breed: _____
6. Weight: _____ 7. Entry Number: _____
8. Trainer's Name: _____
9. Owner's Name: _____

B. IDENTIFICATION OF THERAPEUTIC MEDICATION (MUST BE COMPLETED IF SEC. 8 APPLIES)

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)*:

_____

C. ROMIFIDINE DECLARATION *If applicable (*ALL SIGNATURES BELOW ARE REQUIRED, if any are missing, no matter the circumstances, it will be considered a medications violation and penalties will be applied)*

Amount Administered: _____ Date of Administration: _____

Route of Administration *(Please check one)*: ☐ Intravenous ☐ Intramuscular

Time of Last Administration: _____: _____ a.m. or p.m. *(Please circle one)*

D. SIGNATURES- ALL ARE REQUIRED FOR THIS FORM TO BE SUBMITTED

*Veterinarian Prescribing the Medication:

Print: _____ Sign: _____ Phone Number: _____

*Person Administering the Medication:

Print: _____ Sign: _____ Phone Number: _____

*Rider (Exhibitor) Verification (*if different than person administering- if same please denote*):

Print: _____ Sign: _____ Phone Number: _____

*Owner Verification (*if different than person administering- if same please denote):*

Print: _____ Sign: _____ Phone Number: _____

E. SHOW STEWARD/REP OR DESIGNATED SHOW OFFICE REPRESENTATIVE

Do not accept this form if incomplete.

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/Rep ☐ Designated Show Office Rep *(Please check one):*

Print: _____ Sign: _____ *(Rev. 4/18/2023)*

EFFECTIVE JUNE 2023