



FOR COMPLETION BY TREATING VETERINARIAN

Event: _____

Date: _____

Horses Name: _____

Rider: _____

Horse Owner: _____

Symptoms or condition requiring medication: _____

Medication (including dosage): _____

Active ingredient (see label): _____

Route of administration: Topical Oral Subcutaneous

 Intramuscular Intravenous Rectal

Date and time of administration: __:__:____ Date: _____ Time: _____

Name of Treating Veterinarian: _____ Signature: _____

INSTRUCTIONS TO HORSE OWNER/RIDER: This form must be mailed, faxed or emailed (scan or legible photograph) to the USPA and the form must be RECEIVED PRIOR to the commencement of the USPA event in which the horse is competing. Please retain a file copy of this form and request that your veterinarian retain a file copy of the form.

MAIL: 9011 Lake Worth Road Suite A Lake Worth Florida 33467 FAX: (561) 642-2274 EMAIL: rizzo@uspolo.org

IMPORTANT: All blanks above must complete. Incomplete forms will be returned immediately to the Horse Owner/Rider for completion. Please note whether a specific diagnosis is recorded in proper section above.

IFOR USPA USE ONLY: If all blanks are completed, please indicate the following:

Date Received: _____ Time Received: _____ a.m. p.m.

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

Polo Club City and State: _____

Name and Signature of USPA Official (Please Date Stamp this form as: "RECEIVED BY THE USPA" with the Date/Time received

Print: _____ Sign: _____

Please call (800) 633-2472 if you have any questions about the USPA Equine Drugs and Medication Rules