Request for Medication Administration
USEF Dressage Team Selection

Authorization from the Team Veterinarian must be obtained before the treatment is given.

DATE: _____

PERSON RESPONSIBLE: _____

HORSE: _____

TREATMENT REQUESTED: _____

_____

_____

RATIONALE FOR TREATMENT (Reason for request):_____

_____

_____

TREATING VETERINARIAN: _____ **DATE:** _____

TEAM VET:_____ **DATE:** _____

PERSON RESPONSIBLE:
This document accurately describes therapy given to my horse on _____ (date) at _____ (time of day).

I UNDERSTAND THAT MY HORSE MAY BE DRUG TESTED BY THE USEF PER THE PUBLISHED SELECTION PROCEDURES.

SIGNATURE AND DATE _____

Please keep a copy of this document for your records and submit the original document to Laura Roberts, USEF Managing Director of Dressage, by mail or email within 24 hours (USEF, 4001 Wing Commander Way, Lexington KY 40511 or LRoberts@usef.org)