PENINSULA EQUINE VETERINARIANS
ABN: 25 056 933 142
Dr. Marcus Valmadre B.V.SC
P.O. Box 325
Somerville Vic 3192

CONSENT TO USE EQUITY OESTRUS CONTROL VACCINE

OWNER/AGENT:	HORSE'S NAME:
ADDRESS:	AGE:
	COLOUR:
	BREED: SEX:
	SIRE:
POSTCODE:	DAM:
TELEPHONE:	Microchip Number:
EMAIL:	Nearside Brand:
MOBILE:	Offside Brand:

It has been requested by _____ the above horse is treated with Equity vaccine for the purpose of controlling behaviour.
Before using this vaccine the following points should be remembered.
•This vaccine will affect the function of the ovary.
•This vaccine has been licensed for use in females, but the manufacturer has stated that there is the possibility that after the use of the vaccine the horse will not cycle normally again with a subsequent loss of fertility.
•If it is intended to breed from this horse in the future, the vaccine should not be used.
•For the vaccine to be effective the vaccine will need to be given twice at 30 day intervals followed by a 6 month booster.
Please read the following statements carefully before agreeing to and returning to Peninsula E Veterinarians

1. I, _____ warrant:
(a) I am an agent of the owner/s of _____ and have full authority to act on their behalf.
(b) I have read the manufacturer's specification for the use of Equity Oestrus Control Vaccine for Horses.
(c) I acknowledge it is against the manufacturer's recommendations to use Equity (the Proposed Treatment) in horses intended for breeding or in pregnant mares.

(d) I have not relied upon any representations by Peninsula Equine Veterinarians as to the suitability of the Proposed Treatment.
(e) I acknowledge I have been advised by Peninsula Equine Veterinarians of the risks of using the Proposed Treatment on _____.
(f) I further acknowledge Peninsula Equine Veterinarians expressly denies liability if _____ becomes infertile as a result of having the Proposed Treatment.

2. I and the owners agree to indemnify Peninsula Equine Veterinarians and keep Peninsula Equine Veterinarians indemnified against any claims for loss or damage should _____ become infertile as a result of having the Proposed Treatment.

Date: ……. **by Submitting this form you understand & accept our terms and conditions**

Submit