Veterinary Feed Directive

Veterinarian	_____	Client	_____
Address	_____	Address	_____
City, State, Zip code	_____	City, State, Zip code	_____
Phone	_____	Phone	_____
Fax	_____	Fax	_____
email	_____	email	_____

Drug(s) Name _____Drug(s) dose/duration_____

Species/production class Equine Number of refills authorized_____

If this is a single animal, animal name or ID _____

Indications for use (as approved) _____

Caution (related to this medicated feed, if any) _____

USE OF FEED CONTAINING THIS VETERINARY FEED DIRECTIVE (VFD) DRUG IN A MANNER OTHER THAN AS DIRECTED ON THE LABELING (EXTRA LABEL USE) IS NOT PERMITTED

Approximate number of animals: _____

Premises address: _____

Special instructions (if any): This VFD is being used in accordance with CPG 615.115 for equine. The withdrawal time is not applicable because this horse is not a food producing animal. The medicated supplement Type C reflects the Blue Bird label when given at 1/2 ounce per day for 28 days. The treatment of sarcocystosis due to *S. fayeri* or sporozoites of *S. neurona* using decoquinate is extralabel use. There are no approved medications in horses for this use. The mortality in untreated horses with chronic disease is 20%.

Affirmation of intent (for combination VFD Drugs) (check one box)*:
(*For VFD drugs for which there are no approved VFD combination, only the first affirmation statement should be included on the VFD)

- o This VFD authorizes the use of the VFD drug(s) cited in this order in the following FDA-approved, conditionally approved, or indexed combinations(s) in medicated feed that contains the VFD drugs(s) as a component:

Drug(s)	Drug levels(s) and any special instructions:

Withdrawal time (if any): This VFD feed must be withdrawn ___ days prior to slaughter (indicate N/A if not applicable.
VFD date issue: _____ VFD Expire Date: _____ Expire cannot exceed 6 months after issuance

Veterinary signature: _____ Date signed_____