

PRE-LAMB VACCINE ORDER FORM

NAME _____

ADDRESS _____

PHONE () _____

AFTER HOURS SALES: PHONE GRANT DUFF (06) 374 9180

CAPSULES

BIONIC HI-MINERAL

QUANTITY REQUIRED: _____

DATE REQUIRED: _____

EXTENDER SE CO

QUANTITY REQUIRED: _____

DATE REQUIRED: _____

COGLAVAX 8 in 1

DATE REQUIRED: _____

DOSES REQUIRED: _____

ULTRAVAC 5 IN 1

DATE REQUIRED: _____

DOSES REQUIRED: _____

PLAIN: YES/NO

WITH B12: YES/NO

WITH B12 + SE (Will order as required): YES/NO

MARATHON LA

DATE REQUIRED: _____

DOSES REQUIRED:
(e.g. 2000 doses x 2.5ml)

_____ doses x _____ ml

DOSE RATES

50kg: 2.5ml

60kg: 3 ml

70 kg: 3.5ml

NILVAX

DATE REQUIRED: _____

DOSES REQUIRED: _____

EWEGUARD

DATE REQUIRED: _____

DOSES REQUIRED:
(e.g. 2000 doses x 3.0ml)

_____ doses x _____ ml

DOSE RATES

50kg: 2.0ml

51kg - 62.5kg: 2.5ml

62.5kg - 75 kg: 3.0ml