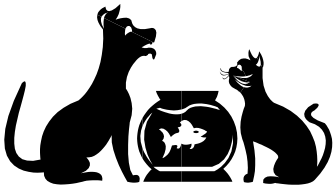
BOARDING DROP-OFF



Owner's Name: _____

Pet's Name: _____ **Date:** _____

Phone #'s: _____

Email Address: _____

Emergency Contact & #: _____

NO DROP-OFFS OR PICK-UPS BETWEEN 12PM – 2PM. $25 WILL BE CHARGED PER PET IF DROPPED OFF OR PICKED UP DURING THIS TIME!!!!!

Date Checking In: _____ **Date Checking Out:** _____

List belongings you have brought with your pet: Include collar and leash colors:

_____

_____

_____

Feeding/Medication Instructions: (if medication(s) are required a $1.50 per medication per administration charge will be added).

_____

_____

_____

CONSENT: In the event of an emergency or if further diagnostics/treatments should be needed, **we will make our best effort to reach you at the number(s) provided above.** However, should we be unable to reach you, please choose and initial one of the following choices:

☐ **I DO** authorize additional treatment without my consent.

- ☐ EMERGENCY ONLY: Up to $ _____
- ☐ Further diagnostics/treatments: Up to $ _____
- ☐ DO whatever is necessary

☐ **I DO NOT** authorize additional treatment of ANY kind without my consent.

I understand that, if I decline additional treatment, do not select either option or am unable to be reached by phone, Amherst Animal Hospital cannot legally continue with diagnostics or treatment of my pet.

Signature of Owner or Authorized Agent X_____

THIS SECTION IS ONLY TO BE FILLED OUT IF YOUR PET IS SEEING THE DOCTOR WHILE HERE!

While my pet is boarding/grooming, I would like the following medical procedures done: (i.e. exam, dental, rabies vaccine, Distemper vaccine, etc.)

_____

_____

Is your pet currently on any medications? ☐ Yes ☐ No If yes, name of medication(s), dose and when last given:

_____

YES	NO		YES	NO	
☐	☐	May we sedate your pet if necessary?	☐	☐	Has your pet had any reaction to vaccines?
☐	☐	Has your pet had any reaction to medications?	☐	☐	Has your pet had any reaction to anesthesia?

HISTORY: Has your pet shown any signs of the following? (Mark any that apply)

☐ Vomiting	How Long:_____	☐ Shaking Head	How Long:_____
☐ Diarrhea	How Long:_____	☐ Scooting	How Long:_____
☐ Lethargic	How Long:_____	☐ Seizures	How Long:_____
☐ No Appetite	How Long:_____	☐ Urinating more/less	How Long:_____
☐ Weakness	How Long:_____	☐ Drinking more/less	How Long:_____
☐ Coughing	How Long:_____	☐ Limping	How Long:_____
☐ Gagging	How Long:_____	☐ Weight loss/gain	How Much? _____
☐ Scratching	How Long: _____	☐ Unusual lump/bump	Where? _____