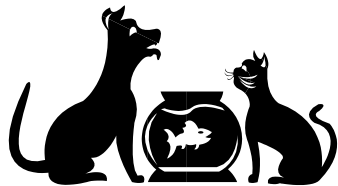


BOARDING DROP-OFF

Owner's Name: _____



Pet's Name: _____

Date: _____

Phone #'s: _____

Emergency Contact & #: _____

Email Address: _____ (If you have access while on vacation) –
You may get a message from your beloved pet and/or one of our staff members updating you on how your pet is doing.

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 _____

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 | |
| <input type="checkbox"/> | <input type="checkbox"/> | May we sedate your pet if necessary? | <input type="checkbox"/> | <input type="checkbox"/> | Has your pet had any reaction to vaccines? |
| <input type="checkbox"/> | <input type="checkbox"/> | Has your pet had any reaction to medications? | <input type="checkbox"/> | <input type="checkbox"/> | Has your pet had any reaction to anesthesia? |

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

- | | | | |
|--------------------------------------|-----------------|--|-----------------|
| <input type="checkbox"/> Vomiting | How Long: _____ | <input type="checkbox"/> Shaking Head | How Long: _____ |
| <input type="checkbox"/> Diarrhea | How Long: _____ | <input type="checkbox"/> Scooting | How Long: _____ |
| <input type="checkbox"/> Lethargic | How Long: _____ | <input type="checkbox"/> Seizures | How Long: _____ |
| <input type="checkbox"/> No Appetite | How Long: _____ | <input type="checkbox"/> Urinating more/less | How Long: _____ |
| <input type="checkbox"/> Weakness | How Long: _____ | <input type="checkbox"/> Drinking more/less | How Long: _____ |
| <input type="checkbox"/> Coughing | How Long: _____ | <input type="checkbox"/> Limping | How Long: _____ |
| <input type="checkbox"/> Gagging | How Long: _____ | <input type="checkbox"/> Weight loss/gain | How Much? _____ |
| <input type="checkbox"/> Scratching | How Long: _____ | <input type="checkbox"/> Unusual lump/bump | Where? _____ |

