



Owner: _____ **Admission Date:** _____ **Discharge Date:** _____

Phone #(s) while out of town: _____

Emergency Contact (Your emergency contact **is required** to be someone local who is willing and able to pick up your pet(s) if necessary, such as in case of weather or facility emergency or other situation.) **The Animal Hospital is authorized to release my pet to the emergency contact. Emergency Contact's Name:** _____ **Phone #:** _____

1. Pet's Name:	2. Pet's Name:	3. Pet's Name:	4. Pet's Name:
1a. Request Bath? <input type="checkbox"/> Yes <input type="checkbox"/> No	2a. Request Bath? <input type="checkbox"/> Yes <input type="checkbox"/> No	3a. Request Bath? <input type="checkbox"/> Yes <input type="checkbox"/> No	4a. Request Bath? <input type="checkbox"/> Yes <input type="checkbox"/> No
1b. <input type="checkbox"/> Own Food** <input type="checkbox"/> Kennel Food Feeding Schedule: <input type="checkbox"/> AM <input type="checkbox"/> PM Special Diet? <input type="checkbox"/> Yes <input type="checkbox"/> No	2b. <input type="checkbox"/> Own Food** <input type="checkbox"/> Kennel Food Feeding Schedule: <input type="checkbox"/> AM <input type="checkbox"/> PM Special Diet? <input type="checkbox"/> Yes <input type="checkbox"/> No	3b. <input type="checkbox"/> Own Food** <input type="checkbox"/> Kennel Food Feeding Schedule: <input type="checkbox"/> AM <input type="checkbox"/> PM Special Diet? <input type="checkbox"/> Yes <input type="checkbox"/> No	4b. <input type="checkbox"/> Own Food** <input type="checkbox"/> Kennel Food Feeding Schedule: <input type="checkbox"/> AM <input type="checkbox"/> PM Special Diet? <input type="checkbox"/> Yes <input type="checkbox"/> No
1c. Medications: <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, please provide med list: name, dose, frequency and when last given on the back of this form.	2c. Medications: <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, please provide med list: name, dose, frequency and when last given on the back of this form.	3c. Medications: <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, please provide med list: name, dose, frequency and when last given on the back of this form.	4c. Medications: <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, please provide med list: name, dose, frequency and when last given on the back of this form.
1d. Any known medical conditions? _____	2d. Any known medical conditions? _____	3d. Any known medical conditions? _____	4d. Any known medical conditions? _____
1e. Other services or treatment you request: _____ _____	2e. Other services or treatment you request: _____ _____	3e. Other services or treatment you request: _____ _____	4e. Other services or treatment you request: _____ _____

Vaccinations: The following vaccines are required for boarding and will be administered upon admission if not current: **Dogs:** Bordetella (within 6 months), DHPP, and Rabies; and **Cats:** FVRCP and Rabies. **If vaccines are given, an exam fee will be charged.**
 _____ (Initial)

Flea and Tick Policy: Any animal admitted that has live fleas and/or ticks will be treated upon admission at owner's expense with product for fleas prevention and will be given a flea and tick bath. _____ (Initial)

Health care and Treatment: Occasionally medical problems may arise or be noticed during a pet's boarding stay. Diarrhea and refusal to eat are not uncommon in boarding pets. In cases when pet is not eating, different types foods will be offered. If your pet develops these or any other medical emergency, the doctor may recommend a physical exam to determine the cause. In order to make a complete diagnosis, additional diagnostics such as x-rays, blood work, urinalysis, fecal analysis or cytology may be required to help determine cause and treatment. The doctor will prescribe and administer medications as needed to treat your pet. I hereby consent to and authorize the performance of necessary tests and initiation of treatment for such condition(s) as are necessary and desirable in the exercise of the veterinarian's professional judgment. If the call first box is checked, the numbers left on this form will be called. If we are unable to reach you, diagnosis and treatment will be started if the doctor determines immediate action is required. _____ (Initial)

I hereby give permission for the doctor to:

- Perform necessary tests. Yes Call first
- Begin treatment. Yes Call first
- Sedate my pet, if necessary. Yes Call first
- Transport to emergency clinic
or specialist if necessary Yes Call first

We now require a **50% deposit** for any boarding. Deposits must be made with credit or cash only. No personal checks permitted. We apologize for any financial inconvenience this may cause. _____ (Initial)

**** See Special Restrictions for Owner Provided Food**

Discharge of patients: Payment in full is required upon discharge. I understand that pets are released only during regular business hours. If I do not pick up my pet within 10 days of the release date listed without further arrangements, the Animal Hospital at Oakleaf Plantation may assume the pet is abandoned. I accept full responsibility for payment of all fees and expenses incurred if I should abandon my pet, including reasonable legal fees if necessary. Even though every attempt will be made to return all items brought with the above pets, the hospital shall not be responsible for the loss or destruction of said items. I hereby acknowledge that I am the owner/agent of the above described animal(s) and have the authority to execute this consent. I have read this release and fully understand the terms and conditions. I certify that I hereby consent and authorize the performance by Animal Hospital at Oakleaf Plantation of the above listed procedure(s) and/or treatment(s).

Owner or Authorized Agent Signature: _____ **Date Signed:** _____

OFFICE USE ONLY
FORM COMPLETED BY: _____

MEDICATIONS

1. Pet's Name:	2. Pet's Name:	3. Pet's Name:	4. Pet's Name:
Please provide list: <ul style="list-style-type: none">• Medication Name• Dose• Frequency• Last given	Please provide list: <ul style="list-style-type: none">• Medication Name• Dose• Frequency• Last given	Please provide list: <ul style="list-style-type: none">• Medication Name• Dose• Frequency• Last given	Please provide list: <ul style="list-style-type: none">• Medication Name• Dose• Frequency• Last given

Special Remarks: