Woofdorf Astoria at Lakewood Ranch

Medical Consent & Release Form

10615 Technology Terrace Suite 104

Lakewood Ranch, FL 34211

Phone: 1-941-758-8226 Fax: 1-941-758-8229 Text: 1-941-400-6831

THIS FORM MUST BE FILLED OUT, SIGNED AND RETURNED

(This form will need to be renewed every January)

The safety and well-being of your dog(s) is of the highest importance to us. Ensuring that your dog remains safe and well-cared for is our first responsibility and as such we take it very seriously.

In the event that a medical emergency arises while a dog is at our facility or participating in service that we provide it is imperative that we are immediately able to get them medical treatment at your vet or the closest available facility. We will call ahead to the veterinary offices as to ensure they can handle the emergency at hand. We will try to get a hold of you first, but in the event we are unable to reach you we will transfer your dog to the veterinary office. Understand that once we are able to reach you we will connect you with the veterinarian so you can discuss your options with a licensed professional.

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Please select an option below to ensure we follow your wishes to the best of our ability.

I authorize any veterinarian selected by Woofdorf Astoria at Lakewood Ranch staff to perform one of the following:

[ ] Do whatever is needed based on the veterinarian's recommendation to keep my dog(s) alive and comfortable until you are able to reach me and I am able to communicate with the veterinarian to make an informed decision

[ ] Do whatever the veterinarian recommends for my dog(s) until you are able to contact me and/or my Emergency Contact **– NOT TO EXCEED $____________** ***Input maximum dollar amount***

[ ] Other: ____

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____***Input your wishes for your canine family member***

I agree that I am financially responsible for any medical treatment my dog(s) receives as a result of a medical emergency while attending Woofdorf Astoria at Lakewood Ranch and agree to pay all charges in full as incurred based on my selection above. I also understand and agree that medical/veterinarian providers give no warranty as to treatment or cure. I understand that I am solely responsible for any injury incurred to my dog(s) and any harm caused by my dog(s) while my dog(s) is/are at Woofdorf Astoria at Lakewood Ranch.

Signature: ____ Date: __________________________

Printed Name: ____