Date: ______________

Client Name: ______________  Pet Name: ______________  Chart Number: ______

Main reason for your pets visit today: __________________________________________

Please initial services to be performed for today:

<table>
<thead>
<tr>
<th>Wellness Exam (required with other services)</th>
<th>Preventative Blood work</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Vaccines</strong></td>
<td><strong>Dogs</strong></td>
</tr>
<tr>
<td>DHPP(Distemper Combo K9)</td>
<td>FVRCP(Distemper Combo Feline)</td>
</tr>
<tr>
<td>Leptospirosis</td>
<td>Leukemia</td>
</tr>
<tr>
<td>Bordetella**</td>
<td>Rabies</td>
</tr>
<tr>
<td>Influenza**</td>
<td>Intestinal Parasite Test</td>
</tr>
<tr>
<td>Rabies**</td>
<td>FeLV/FIV Test</td>
</tr>
<tr>
<td>Heartworm Test</td>
<td>(recommended for outdoor cats)</td>
</tr>
<tr>
<td>Intestinal Parasite Test</td>
<td>ProHeart Injection</td>
</tr>
</tbody>
</table>

**Vaccination Policy:** To ensure the protection of all the pets under our care, the following vaccines must be up to date prior to your scheduled boarding date.

DOGS: Rabies; Distemper/Parvo (DHPP); Bordetella, Influenza (Flu)**

CATS: Rabies; FVRCP (Distemper)

Check all concerns you have for your pet:

___ Vomiting/Diarrhea
___ Lethargy/Weakness
___ Behavioral Changes
___ Coughing/Sneezing
___ Change in Eating
___ Change in Drinking
___ Itchiness: Skin
___ Urinary Problems
___ Seizures
___ Itchiness: Ears
___ Eyes
___ Limping
___ Weight Concerns
___ Lumps
___ Mouth

Tests may need to be conducted for proper diagnosis of sick patients:

☐ I authorize up to $___________ in medical care until someone can be reached.

☐ Do not administer any medical treatment until specific authorization is given.

Please understand a veterinarian or staff member may need to contact you to discuss the treatment of your pet. Please provide the primary contact information so we do so in a timely manner.

Primary #: ___________________  Secondary #: ___________________  Email: ___________________
Please list all medications your pet is currently taking and when they were last given:

<table>
<thead>
<tr>
<th>Medication</th>
<th>Time</th>
<th>Refills Needed?</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>___ AM / PM</td>
<td>YES / NO</td>
</tr>
<tr>
<td>2.</td>
<td>___ AM / PM</td>
<td>YES / NO</td>
</tr>
<tr>
<td>3.</td>
<td>___ AM / PM</td>
<td>YES / NO</td>
</tr>
<tr>
<td>4.</td>
<td>___ AM / PM</td>
<td>YES / NO</td>
</tr>
<tr>
<td>5.</td>
<td>___ AM / PM</td>
<td>YES / NO</td>
</tr>
<tr>
<td>6.</td>
<td>___ AM / PM</td>
<td>YES / NO</td>
</tr>
</tbody>
</table>

Would you like any additional services for your pet today? Check all that apply

- [ ] Microchip
- [ ] Nail Trim
- [ ] Bath
- [ ] Express Anal Glands

Your pet will be checked for fleas while in hospital. If fleas are noted, Capstar (a fast acting flea treatment) will be given for the safety of pet and the hospital. The cost of treatment will be added to your invoice.

Please be advised that the veterinarian will see your pet at their earliest convenience between appointments and surgeries.

If hospitalization is needed, please be aware a deposit is required prior to admittance and the balance will be due at time of discharge. If you have financial concerns, please discuss them with your client care specialist PRIOR to authorizing care.

I, the undersigned owner or agent of the pet named above, certify that I am 18 years of age or older and authorize the veterinarians of Quail Corners Animal Hospital to treat or perform needed procedures on my animal.

Signature of Owner: _______________________________ Date: __________________________

FOR STAFF USE ONLY

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________