

**BOARDER INFORMATION**

**Please complete form and bring it with you on the day of your boarding**

Owner Name \_\_\_\_\_ Date IN: \_\_\_\_\_ Date Out \_\_\_\_\_

Dog Name \_\_\_\_\_ Breed \_\_\_\_\_ Color \_\_\_\_\_ M/F \_\_\_\_\_

Dog Name \_\_\_\_\_ Breed \_\_\_\_\_ Color \_\_\_\_\_ M/F \_\_\_\_\_

Dog Name \_\_\_\_\_ Breed \_\_\_\_\_ Color \_\_\_\_\_ M/F \_\_\_\_\_

Cat Name \_\_\_\_\_ Breed \_\_\_\_\_ Color \_\_\_\_\_ M/F \_\_\_\_\_

Cat Name \_\_\_\_\_ Breed \_\_\_\_\_ Color \_\_\_\_\_ M/F \_\_\_\_\_

**FEEDING INSTRUCTIONS**

**(If you do not bring your own food we feed Science Diet and ProPlan. Please check which food you wish us to use)**

**Science Diet**

- S.D SENSITIVE STOMACH
- S.D LITE
- S.D SMALL BITES
- MATURE

DRY  CANNED

1X AM  1XPM  2 X  3X  LEAVE OUT

**PROPLAN**

- PP ADULT CHICKEN/RICE
- PP ADULT SENS. SKIN/STOM
- PP PUPPY CHKN/RICE
- PP LITE
- PP SMALL BITES
- PP SENIOR

**HOW TO FEED**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Your pet's food Brand \_\_\_\_\_

1X AM  1XPM  2 X  3X  LEAVE OUT

**Please bring your food in a Container or bag with your pets first and last name.**

**MEDICATION**

**All medication must be in the prescribe bottle**

Medication \_\_\_\_\_

Directions \_\_\_\_\_

Medication \_\_\_\_\_

Directions \_\_\_\_\_

Medication \_\_\_\_\_

Directions \_\_\_\_\_

Flea Medication  Yes  No

**EXTRA'S**

TBR  YES  NO

VETERINARIAN PREFERENCE \_\_\_\_\_

FECAL  YES  NO

VETERINARIAN PREFERENCE \_\_\_\_\_

SURGERY  YES  NO

VERERINARIAN PREFERENCE \_\_\_\_\_

GROOM  YES  NO

Bath  YES  NO

**BELONGINGS**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**OUR DOCTORS**

DR. SMITH

DR. KAPTAN

DR. SCHELLE

**Overall Consent:** I understand that there is a charge for additional elective services such as dental, grooming and micro-chipping. For the safety of the boarders, all pets with fleas, ticks, or other parasites will be treated at owner's expense if identified on your pet. I certify that I, the owner of the above listed pet, I do hereby release County Animal Hospital from all liability related to care provided. I acknowledge that I am responsible for payment in full for all treatments and care at time of pick-up.

**SIGN** \_\_\_\_\_

**DATE** \_\_\_\_\_