

Requested Boarding Services for " {NAME}" {LASTNAME}

Dates boarding: _____ to _____ DOB: {BIRTHDATE[SHORT]} Weight at Check In: _____

Species: {SPECIES} Breed: {BREED} Color: {COLOR} Sex: {SEX}

Patient Allergies or Alerts: {ALLERGICTO}/ {PATIENTSPECIALALERT}

FEEDING INSTUCTIONS: _____ OWNER'S FOOD*

MEDICATIONS*: _____
(Must be in original packaging due to AAHA regulations. Additional fee applies for medication administration.)

PROVIDE MY PET WITH BEDDING: YES NO OWN BEDDING

(I understand that there are risks associated with my pet having blankets, beds, toys, etc. in their cage. I accept full financial responsibility for any treatments necessary should my pet ingest any of the above listed items. I also understand that any of my pet's belongings may be lost despite the staff's best efforts and will not hold Fort Hunt Animal Hospital accountable for any such loss.)

GROOMING SERVICES*:

Nail trim_____ Clean ears_____ Bath_____ Other _____

Pets will be ready to pick up after 4pm on their last day of boarding when a bath is requested.

Pets leaving on Saturday will be bathed the preceding **Friday**.

OTHER SERVICES/NEEDS:

*Dogs are walked starting at 7:00 am and 4:30 pm each day. Additional walks can be provided for an additional fee.

Both extra walks are REQUIRED for puppies under 4 months of age.

noon extra walk 7:00 pm extra walk

*Cats receive 10 minutes of playtime by request for an additional fee.

AM playtime (10 minutes) PM playtime (10 minutes)

IMPORTANT! PLEASE READ CAREFULLY: In the event that your pet becomes ill while boarding, we will attempt to contact you at the emergency number listed below. If we are unable to reach you, do you want us to begin treating your pet or wait until we are able to reach you? Treat immediately up to \$_____ Do NOT treat until I have been reached

In a life threatening emergency:

_____ I authorize whatever services the doctor deems necessary for the best care of my pet **OR**

_____ I direct the doctor to only provide those services necessary to keep my pet comfortable and alleviate pain.

CONTACT NAME: _____ PHONE: _____

E-MAIL: _____

I have reviewed and approve all of the above. Signature: _____

Canine:		Feline:	Staff Checked in: _____ Verifier: _____
<input type="checkbox"/> Rabies_____	<input type="checkbox"/> Lyme_____	<input type="checkbox"/> Rabies_____	<input type="checkbox"/> Wellness Exam_____
<input type="checkbox"/> DHPP/DHLPP_____	<input type="checkbox"/> 4-DX_____	<input type="checkbox"/> FVRCP_____	
<input type="checkbox"/> Lepto_____	<input type="checkbox"/> Fecal_____	<input type="checkbox"/> FELV_____	
<input type="checkbox"/> Bord (Oral/IN)_____	<input type="checkbox"/> Wellness Exam_____	<input type="checkbox"/> Fecal_____	

Pet	{NAME}	Client	{LASTNAME}	Age	{AGE}
Breed	{BREED}	Color	{COLOR}	Sex	{SEX}
In	{ARRIVALDATE[SHORT]}	Out	{DEPARTUREDATE[SH ORT]}		

Alerts	{PATIENTSPECIALALERT}	Allergies	{ALLERGICTO}
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Medications: Yes No

Feeding Instructions: _____

Date	Shift	Urine	Stool	Appetite	Staff	Comments	Staff Fed
	AM					Initial weight: _____	
	PM						
	AM						
	PM						
	AM						
	PM						
	AM						
	PM						
	AM						
	PM						
	AM					Check weight: _____	
	PM						
	AM						
	PM						

N = Normal A: Absent D: Diarrhea* V: Vomit* *Notify hospital staff

" {NAME}" {LASTNAME}

Belonging:	Description:	Location:	Collected?
Own Food			
Food Container			
Leash/Collar			
Carrier			

Other Belongings:	Description:	Location:	Collected?