Drop-off Form

Owner's name: _____ Pet's name: _____

Contact information and best times to call: _____

Items with pet (circle): Leash Collar Carrier Other: _____

What's happening with your pet, and for how long has it been going on? _____

_____

_____

_____

_____

Other useful medical history (circle symptoms)

Coughing Sneezing Vomiting Diarrhea Changes in urination Changes in activity

Changes in eating/drinking Other: _____

Describe the frequency of the above symptoms: _____

_____

List your pet's current medications and supplements: _____

_____

Anything else you'd like us to know or do for your pet? _____

_____

_____ (Initial) I authorize the doctors/staff to examine the pet and provide care as needed within a budget of $_____ and to contact me if anything would go beyond expected treatment.

_____ (Initial) I authorize the doctors to use sedation (if needed) without contacting me.

Signature: _____ Date: _____

Clinic use only: History Label White-board