4342 HAINES ROAD
ST. PETERSBURG, FL, 33714
(727) 525-2118

OWNER **<client>** PETS NAME **<animal>**
BREED **<breed>** AGE **<age>**

VACCINATIONS DUE <overdue>__

_____ will be picking up <animal> from boarding on _____.
Name Pick Up Date

DIET

☐ I brought <animal>'s own food ☐ Please feed <animal> your food

I would like <animal> to be fed _____ cups/cans of food _____times a day.

SPECIAL INSTRUCTIONS

_____

MEDICATIONS – *There is an additional fee for giving medications while boarding*

Medication:_____Dosage_____How Often?_____Last Given?_____
Medication:_____Dosage_____How Often?_____Last Given?_____
Medication:_____Dosage_____How Often?_____Last Given?_____
Medication:_____Dosage_____How Often?_____Last Given?_____

ADDITIONAL SERVICES AVAILABLE

☐ Bath ☐ Nail trim ☐ Anal Glands ☐ Ear Plucking ☐ Ear Cleaning

EMERGENCY CONTACT INFORMATION

Emergency Contact Name:_____ Phone Number:_____
Alternate Emergency Contact Name:_____ Phone Number:_____

Important Information

Please Initial

_____**All pets must be up to date on all vaccinations and free of internal and external parasites**. Due to the facts that we are a Flea Free Facility, all pets must receive a dose of capstar upon admittance to the hospital for boarding.

_____**Our standard pick up times are Monday – Friday from 2 PM until 6 PM and on Saturdays from 10AM until 12 PM**. Picking up your pet outside of these scheduled times may result in a greater wait. If you need to pick up outside of these times, please speak with our boarding director, so that we may have you pet ready to go home at the proper time.

_____**Likewise, I will call if my "pick-up date" changes so you can plan accordingly.** If I neglect to pick up my pet within 7(seven) days of the date scheduled for discharge and do not notify Haines Road Animal Hospital within that time period, you may assume that the pet is abandoned and are hereby authorized to seek placement for the pet as you deem best and/or necessary.

_____We require the kennel cough vaccine for dogs to board at our facility. Unfortunately vaccines are not 100% effective as well as the fact that the strain can mutate. If your pet develops kennel cough while at our facility, we will treat accordingly. Due to the circumstances, we will only be charging for the injectable and oral medications used and sent home. **I understand that there is a risk of my pet developing kennel cough and I am willing to accept the financial responsibility of treatment for my pet.**

_____ **Some pets can develop a condition known as stress colitis while boarding**. This can be brought on by numerous factors including a change of environment, change of diet, or even just a change in the pet's normal routine.

_____**Owners of two or more dogs:** I give permission for my dogs to be walked together.

Canine influenza is a respiratory disease that can cause coughing, runny nose, watery eyes, loss of energy, fever and/or loss of appetite. With proper care, most dogs generally recover. However, canine influenza can lead to more severe or even life-threatening infections, such as pneumonia. Since canine influenza is highly contagious, visiting places where dogs congregate, such as kennels, doggie daycares, dog parks, or grooming facilities, puts dogs at higher risk for catching this virus. Making things more difficult is the fact that dogs can spread the virus before the coughing and other signs of sickness appear. Vaccinating your dog can help reduce the risk of contracting canine influenza. The cost of the vaccine is $34.50 and if your pet has never been vaccinated before, they will require a booster in 2-4 weeks.

_____ I **approve** vaccinating my pet for canine influenza.

_____ I **decline** vaccinating my pet for canine influenza.

_____ My pet is already vaccinated for canine influenza. They were vaccinated at_____.

I understand that in the event of my pet's illness, the staff will immediately attempt to contact me or my agent to discuss the problem and treatment options, but may not be able to contact me immediately and is therefore authorized to initiate appropriate treatment until myself or my agent can be reached.

If any problem is observed or develops: **Doctor Preference _____**

_____ I approve treatment up to _____ dollars.

_____ Perform only emergency and supportive care. Notify me for permission to begin other treatment.

_____ Do not perform any diagnostics and/or treatment until I am notified and consent for you to evaluate and treat as recommended.

OWNERS SIGNATURE_____**DATE**_____

WITNESS_____**DATE**_____