

# COMPANION CARE VETERINARY CLINIC

## BOARDING CONSENT FORM

Admitted By: <current-username>  
Admission Date: <CHECK-IN>  
Expected Discharge Date: <CHECK-OUT>

1. All pets must be current on their vaccinations. This includes Bordetella, Distemper combo, Rabies for dogs. FVRCP and Rabies for cats. Written proof of vaccinations or verification must be provided before boarding pet(s).
2. Yearly fecal exams required prior to boarding. If parasites are found on the pet during the stay, they will be treated as necessary and the cost will be reflected on the total bill.
3. If the pet must be separated from the general population and put in quarantine ( for either aggression or illness), additional charges will be added to total bill.
4. All reasonable precautions will be used to prevent injury and escape of the pet. Companion Care Veterinary Clinic is not responsible for the actions of the pet that may cause injury or escape.
5. All pets not picked up within expected date provided will be considered abandoned with out contact of other arrangements made by owner. Companion Care Veterinary Clinic is given authorization to dispose of the pet as they deem best.
6. Medications and feeding times will generally be done during business hours. Medications/treatments will incur additional fees.
7. Sorry, we do not arrange for Sunday pick-ups.

### TREATMENT CONSENT

\_\_\_\_\_ DO NOT treat my pet if illness occurs, regardless of suspected outcome. I understand that my pet may undergo needless pain and suffering due to lack of medical treatment. I will be responsible for all charges accrued during my pet's stay.

Signature \_\_\_\_\_ Date \_\_\_\_\_

\_\_\_\_\_ TREAT my pet as needed, but do not exceed \$ \_\_\_\_\_. I understand that if the proposed treatment exceeds the amount designated, and I or my agent cannot be contacted, my pet will NOT receive further medical treatment. I will be responsible for all charges accrued during my pet's stay.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Contact Name \_\_\_\_\_ Contact Phone \_\_\_\_\_

FEEDING INSTRUCTIONS: \_\_\_\_ CUPS OF (A) YOUR FOOD \_\_\_\_ OR (B) CLINIC FOOD \_\_\_\_\_,

HOW MANY TIMES PER DAY? \_\_\_\_\_

ANY SPECIAL FEEDING INSTRUCTIONS \_\_\_\_\_

LIST ALL BELONGS – (PLEASE MAKE SURE THE BAGS/CONTAINERS ARE LABELED) \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_