Animal Medical & Surgical Center

NORTH SCOTTSDALE

BOARDING INFORMATION

Pet Owner:
Pet Name:
Date Admit:
Date Discharge:
Condo/Cage/Run #:
Weight:

VACCINATION DUE DATES				
DHPP:	DHP:	PARVO:	BORDETELLA:	RABIES:
FVRCP:		FELV TEST(<1YR)/FELV VX (<3 YRS):		

EMERGENCY CONTACT NUMBERS			
NAME:	NUMBER:	NAME:	NUMBER:
My emergency contact is authorized to make decisions on my behalf:______________________________(owner signature)			

PET BELONGINGS	
CHECK IN:	CHECK OUT:
Please remember that we cannot insure the safe return of any item left while boarding at our facility.	

SPECIAL INSTRUCTIONS:	
MEDICAL CONDITIONS:	
MEDICATIONS:	☐ YES ☐NO IF YES, SEE MEDICATION SHEET

FEEDING INSTRUCTIONS			
OWN FOOD: ☐YES ☐NO	BRAND:	QUANTITY:	_____TIMES/DAY
MY PET HAS ALREADY BEEN FED TODAY: YES NO			
Special Instructions:			

PLAYTIME (If your pet is older than 6 months, they must be neutered to enjoy playtime)
Does your dog play well with others? YES NO If so, would you like your pet to have playtime with other animals?: YES NO
Playtime will be based on the boarding supervisor's opinion. Only dogs with compatible temperaments will be permitted to play together, and the boarding staff will accompany them at all times.

ESTIMATED EXPENSES			
BOARDING:	DAILY MEDICATION:	INSULIN:	BATH:
EXAM:	DHPP:	BORDETELLA:	RABIES:
FVRCP:	FELV:	FLEA/TICK PREVENTION:	OTHER:
BOARDING STAFF CHECKING IN:			

AUTHORIZATION FOR MEDICAL TREATMENT
If your pet becomes ill or injured, or if the state of your pet's health otherwise requires professional attention, AMSC will make a reasonable attempt to contact you (the owner), but in its sole discretion, may provide veterinary services, and the expenses thereof shall be paid by the Owner. I authorize Animal Medical & Surgical Center to treat in the best interest of my pet, for medical conditions that may arise, and the associated charges. OWNER SIGNATURE:
REFUSAL OF MEDICAL TREATMENT
In the event that my pet becomes ill or injured, or if the state of my pet's health otherwise requires professional attention, I DO NOT authorize AMSC to provide veterinary services. If any adverse medical problems occur because of my decision to refuse veterinary services, I accept full financial and medical responsibility for my decision, and I release the staff at this veterinary practice of all responsibility for my decision.I understand the medical risks for my pet and that those risks may include death.
OWNER SIGNATURE:

- All pets must be current on their vaccinations. If we do not serve the veterinary needs of your pet at our facility, please provide us with records of your pet's vaccination history.
- Your pet will be treated for external parasites upon entrance at an additional charge, if needed, as not to contaminate this facility or the other pets staying here.
- It may be necessary to temporarily move your pet from their assigned run or cage in order to maintain a clean and sanitary environment.
- I understand my pet may require light sedation if he or she becomes overly stressed or anxious while boarding.
- WE WILL NOT RELEASE PETS AFTER BUSINESS HOURS OR ON HOLIDAYS – OWNER INITIALS ________

SIGNATURE: ______________________________ DATE: ______________

Animal Medical & Surgical Center

NORTH SCOTTSDALE

Medication Key
sid: once a

Boarding Medication Form

Pet:________________ Client:_______________________ Room:________

PRESCRIPTION 1:		DIRECTIONS:							
		1st Dose		2nd Dose		3rd Dose		4th Dose	
Day of Stay	Date	Time	Employee	Time	Employee	Time	Employee	Time	Employee
Day 1									
Day 2									
Day 3									
Day 4									
Day 5									

Were medications given by owner today: Yes No _________________________ Owner Initials: _________

PRESCRIPTION 2:		DIRECTIONS:							
		1st Dose		2nd Dose		3rd Dose		4th Dose	
Day of Stay	Date	Time	Employee	Time	Employee	Time	Employee	Time	Employee
Day 1									
Day 2									
Day 3									
Day 4									
Day 5									

Were medications given by owner today: Yes No _________________________Owner Initials: _________

PRESCRIPTION 3:		DIRECTIONS:							
		1st Dose		2nd Dose		3rd Dose		4th Dose	
Day of Stay	Date	Time	Employee	Time	Employee	Time	Employee	Time	Employee
Day 1									
Day 2									
Day 3									
Day 4									
Day 5									

Were medications given by owner today: Yes No _________________________Owner Initials: _________

PRESCRIPTION 4:		DIRECTIONS:							
		1st Dose		2nd Dose		3rd Dose		4th Dose	
Day of Stay	Date	Time	Employee	Time	Employee	Time	Employee	Time	Employee
Day 1									
Day 2									
Day 3									
Day 4									
Day 5									

Were medications given by owner today: Yes No _________________________Owner Initials: _________