



Boarding Drop-Off Consent Form

Client's Name _____ Pet's Name _____
Drop Off Date _____ Pick Up Date _____

_____ I grant Delhomme Animal Clinic permission to post my pet's picture, story and medical information on social media.

Emergency Contact Information

Name _____ Phone Number _____
Name _____ Phone Number _____
Name _____ Phone Number _____

Standard Fees:

Dogs 0-25lb \$22.50/night | Dogs 25-50lb \$25/night | Dogs 51-75lb \$26.25/night

Dogs 76-100lb \$28.75/night | Dogs +101lb \$31.25/night | Cats \$18.00/night

Check In

Monday through Friday 11:00am to 3:00pm
Saturday 8:00am to 10:00am.

Check Out

Monday through Friday 2:00pm to 4:00pm
Saturday 9:00am to 12:00pm
Sunday 5:00pm to 5:30pm

Does your pet require any medication? (*circle one*) **Yes No**

If yes, what are the instructions? _____

Does your pet have any medical issues you would like addressed? (*circle one*) **Yes No**

If yes, what are the details? _____

Did you bring your pet's own food? (*circle one*) **Yes No**

How often does your pet eat? _____ How much do you offer at each feeding? _____

We feed Hill's Science Diet Chicken & Barley if you did not bring your pet's food.

Does your pet have any known allergies? (*circle one*) **Yes No**

Can your pet have blankets/toys in kennel? (*circle one*) **Yes No**

List all personal belongings left with your pet: **(We are not responsible for any lost items)** _____

Any Special instructions? _____

Does your pet have storm/firework anxiety? _____ Are you interested in treating it? _____

****Weekday Pickup Only**** Would you like your pet to have a bath (\$19.00) before leaving? (*circle one*) **Yes No**

PLEASE INITIAL:

_____ In the event of an emergency or illness while boarding, we will treat your pet for illness at your expense. We want to keep all pets healthy.

_____ Your pet needs to be current on all vaccinations and free from internal and external parasites. This policy protects your pet as well as other animals. If your pet is not current on vaccinations or shows signs of any parasites, these treatments will be done at your expense.

Printed Name _____ **Signature of Owner or Authorized Agent** _____

Preferred Contact Method:

email: _____ *text:* _____ *voice:* _____