



Owner: <first-name> <last-name> Acct. <number> Date: <date>

<address> <city>, <st> <zip>

Cell Phone: <cell-phone> Home Phone: <phone>

Patient: <animal> <sex> <breed> <age> <color>

## Hospitalization / Treatment Consent Form

Reason for visit: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### Patient information:

Vomiting? yes / no      Diarrhea? yes / no  
Is your pet taking any medications? (if so please list) \_\_\_\_\_  
If yes when was the last dose given \_\_\_\_\_  
Any illness or injury in the last 30 days? \_\_\_\_\_  
Any allergies to medications? \_\_\_\_\_  
Did your pet eat this morning? ☐ No    ☐ Yes    At what time? \_\_\_\_\_

### Hospitalization/Treatment Consent:

I certify that I own/have assumed financial responsibility for the above-described animal. I do hereby consent and authorize the Powhatan Animal Hospital and its staff to hospitalize this animal, and to administer vaccinations, medications, tests, surgical procedures, anesthetics or treatments that the doctors deem necessary for the health, safety, or well-being of the above animal while it is under their care and supervision. Veterinary services during nighttime hours, and/or weekends, are provided at the discretion of the veterinarian in charge. Continuous presence of personnel may not be provided during these hours. If the animal should injure itself in an escape attempt, refuse food, soil itself, become ill, or die while in the hospital, I will hold the Powhatan Animal Hospital free of any responsibility and/or liability in the absence of gross negligence. I further realize that I am responsible for the payment of the above procedures and treatments in full at the time the animal is discharged.

Pets must be free of internal and external parasites, such as fleas, ticks, and intestinal parasites, as they are transmissible to other pets. If present, treatment will be given at the owner's expense.

Name: \_\_\_\_\_

Date: \_\_\_\_\_

Signature: \_\_\_\_\_

### Phone numbers where you can be reached today:

Primary contact number/name: \_\_\_\_\_

Secondary contact number/name: \_\_\_\_\_

Staff Initials: \_\_\_\_\_