



# Boarding Admission



<last-name>, <animal>

<breed>

<color>

<age>

<sex>

Drop Off Date: <date>

Pick Up Date: \_\_\_\_\_

Before 12:00 p.m.

After 12:00 p.m.

Sunday Monday Tuesday Wednesday Thursday Friday Saturday

## Vaccinations

### Canine

### Date Given

### Feline

### Date Given

DHPPC

\_\_\_\_\_

FVRCCP

\_\_\_\_\_

Bordetella

\_\_\_\_\_

Rabies

\_\_\_\_\_

Rabies

\_\_\_\_\_

★ Proof of vaccine history is required at time of drop off if current records are not on file at MBPH ★

**Vaccination Requirement:** "I understand that state law requires Rabies vaccination for all pets. I also understand clinic policy requires the DHPPC and Bordetella vaccines for dogs and FVRCCP for cats to be current. If my pet is not current on vaccines I authorize Mast Blvd Pet Hospital to administer vaccines to my pet in order for he/she to board."

Owner Initial: \_\_\_\_\_

### Medical Services Requested At Additional Charge:

Exam / Consultation (\$40.50)

Yes

No

Specific Problem: \_\_\_\_\_

Fecal Test (\$27.50)

Yes

No

Heartworm/LY/EC TEST (\$40.00)

Yes

No

DHPPC (\$23.10)

Yes

No

Bordetella (\$18.50)

Yes

No

Felv/Fiv Test (\$48.00)

Yes

No

FVRCCP/Leukemia (\$39.75)

Yes

No

Rabies (\$12.50)

Yes

No

If Rabies is the only vaccination your pet needs, the charge will be \$25.00

### Optional Services Available At An Additional Charge:

Bath, Nail Trim, Anal Gland Expression (charged by weight)

Yes

No

(If boarding for 4 or more days, a complimentary bath will be given unless otherwise specified)

Is <animal> on a monthly flea preventative?

Yes

No

If evidence of fleas are present flea control will be given at time of admission and will be added to the boarding charges.

Is <animal> allergic to any drugs or have food allergies?  
If so, What? \_\_\_\_\_

Yes

No

Has <animal> had an illness/injury in the past 30 days?  
If so, What? \_\_\_\_\_

Yes

No

Is <animal> on any medication(s)?  
If so, What? \_\_\_\_\_

Yes

No

(There is an additional \$5.20 per day charge for daily medication administration)

Medication(s) Schedule \_\_\_\_\_  
\_\_\_\_\_

### **Feeding Instructions:**

Current Diet: \_\_\_\_\_

Feeding Schedule: \_\_\_\_\_  
\_\_\_\_\_

(If pet is not sent with food or with enough food, there is an additional \$4.20 per day charge for hospital food)

**Pet's Belongings:** \_\_\_\_\_  
\_\_\_\_\_

### **Abandonment Notice**

I will call if my "pick-up date" changes so you can plan accordingly. If I neglect to pick up <animal> within 5 days of the date scheduled for discharge, and do not notify you within that time period, you may assume that <animal> is abandoned and are hereby authorized to dispose of <animal> as you deem best and/or necessary.

### **Owner Release**

- I understand you cannot guarantee the health of <animal>. I understand and will not hold the clinic responsible for conditions that are unavoidable in boarding kennels, such as not but not limited to weight loss, hair loss, upper respiratory infections, bronchitis, diarrhea, and fleas. I understand all pets admitted to the clinic must be protected against communicable contagious diseases and must be free of internal and external parasites or will be treated on entry or discovery at the owner's expense.
- I understand that the clinic is not responsible for loss or damage to personal items left with pet including but not limited to leashes, collars, harnesses, toys, food and bedding.
- The clinic is to use all reasonable precaution against injury, escape, or death to <animal>. The clinic and staff will not be held liable for any problems that develop provided reasonable care and precautions are followed. I understand that any problem that develops with <animal> will be treated as noted below and I assume full responsibility for the treatment expense incurred.
- I understand there is an additional charge for any pet deemed aggressive during the boarding period.

**If any problem is observed or develops: (please initial)**

\_\_\_\_\_ Please treat <animal> as required and you need not to call me.

\_\_\_\_\_ Perform only emergency and supportive care. Notify me for permission to begin any other treatment.

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

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

<date>

Drivers License # \_\_\_\_\_

**Name(s) and Phone Number of Responsible Party(s) to be reached in an Emergency**

Name: \_\_\_\_\_ Phone Number: (     )

Name: \_\_\_\_\_ Phone Number: (     )

**Additional Notes**

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