

**All Creatures Small Animal Hospital**

**Boarding Admission Form**

Admission by: \_\_\_\_\_

Date of Admission: \_\_\_\_\_

Expected discharge date: \_\_\_\_\_

Contact name (if not owner): \_\_\_\_\_

Contact person's phone number: \_\_\_\_\_

1. All pets boarding must be current on vaccinations:  
Dogs: DPCB w/ Lepto, Bordetella, and Rabies, Fecal  
Cats: FVRCP and Rabies  
Written proof of vaccines or verification with pet's veterinarian must be provided before boarding the pet(s)
2. A negative Intestinal Parasite Screen (Fecal) will be **REQUIRED** for boarding. Intestinal parasite screen must have been performed and found to be negative within the past 12 months. If any parasites are found on the pet during their stay with us, the pet will be treated as All Creatures Small determines, and the cost of the treatments will be added to your total bill.
3. We will try to bathe and trim nails on all dogs prior to discharge as a complimentary service. However, if the pet's health or temperament makes it hazardous to the staff or the pet, the pet will not receive a nail trim or a bath.
4. If the pet is to be picked up by someone other than the owner, arrangements must be made with us regarding the bill prior to leaving.
5. All reasonable precautions will be used to prevent injury and escape of the pet. All Creatures Small is not responsible for actions of the pet causing injury and escape.
6. All pets not picked up within seven days after the expected date of discharge, without word of changing discharge dates from the owner, the pet(s) will be considered abandoned.

**Turn Page Over**

**Options regarding the treatment of my pet during its stay: ONLY NEED TO SIGN ONE**

- a. Treat my pet as needed. Do any and all diagnostic testing, treatments, and surgeries recommended for the well-being of my pet(s). I accept full financial responsibility for all charges related to the treatment of my pet(s).

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

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

- b. Treat my pet(s) as needed, but not to exceed \$\_\_\_\_\_. I understand that if the proposed treatment exceeds the amount designated, and I or my agent can not be contacted, my pet will NOT receive further medical treatment even if it is life threatening. I understand that if Dr. Telleen and/or her associates feel that my pet is undergoing needless pain and suffering due to the lack of medical care, and that the treatments and test needed would exceed the above amount Dr. Telleen and her associates are authorized to euthanize (put to sleep) my pet. I will be responsible for all charges accrued during that time period.

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

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

- c. Treat my pet(s) as needed. Do any and all diagnostic testing, treatments, and surgeries necessary. However, should the veterinarian determine that my pet(s) require extensive measures to maintain life, I request that they euthanize (put to sleep) my pet(s). I understand that the interpretation of "extensive measures" is left to discretion of the doctor. I accept full financial responsibility for all charges related to the treatment of my pet.

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

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

- d. Do not perform any diagnostics or treatments without contacting me first. If I cannot be reached at the phone number(s) I have provided, consider all testing and treatments declined.

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

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