DOGGIE DAY CARE AGREEMENT

10555 West Maple Wichita, KS 67209
Telephone: (316) 722-1921
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TELL US ABOUT YOURSELF

NAME:_____
ADDRESS:_____ **APT #:**_____
CITY:_____ **STATE:**_____ **ZIP:**_____
HOME PHONE:_____ **CELL PHONE:**_____
WORK PHONE:_____ **EMERGENCY PHONE:**_____
EMAIL:_____
WHO ELSE IS AUTHORIZED TO DROP OFF/PICK UP THE PET?_____
INSTRUCTIONS IN CASE OF EMERGENCY:_____
HOW DID YOU HEAR ABOUT US?_____

TELL US ABOUT YOUR PET(S)

NAME:_____**BREED:**_____**DOB/AGE:**_____
SEX: M F SPAYED/NEUTER: Y N (IF FEMALE UNSPAYED, DATE OF LAST CYCLE):_____
WEIGHT:_____ **COLOR:**_____

TELL US ABOUT YOUR PET'S HEALTH

VETERINARIAN CLINIC:_____
ADDRESS:_____
PHONE NUMBER:_____
BRING PROOF OF VACCINATIONS AND NEGATIVE FECAL
CURRENT MEDICATIONS:_____
FREQUENCY AND TIME ADMINISTERED:_____

I CERTIFY THAT I AM THE OWNER OR THE AGENT OF THE OWNER OF THE AFOREMENTIONED PET, AND I AM AUTHORIZED TO BOARD THE PET AND SIGN THIS FORM. I AUTHORIZE COMPANION ANIMAL HOSPITAL TO CONTACT MY VETERINARIAN IN ORDER TO CONFIRM HEALTH, TEMPERAMENT AND VACCINATIONS. I AUTHORIZE COMPANION ANIMAL HOSPITAL TO ACT ON MY BEHALF BY OBTAINING VETERINARY CARE AT MY EXPENSE, SHOULD COMPANION ANIMAL HOSPITAL DEEM IT NECESSARY. I HAVE READ THE SCHEDULE OF FEES AND AGREE TO PAY ALL CHARGES AT CHECKOUT, UNLESS PREVIOUSLY ARRANGED. I AUTHORIZE COMPANION ANIMAL HOSPITAL TO CHARGE MY CREDIT CARD ACCOUNT, IF SO PROVIDED, FOR ANY LIABILITY OR CLAIMS DUE TO INJURY OR DEATH OF MY DOG, UNLESS COMPANION ANIMAL HOSPITAL HAS BEEN NEGLIGENT IN THE CARE OF MY DOG.

I UNDERSTAND THAT MY DOG WILL BE PLAYING WITH OTHER DOGS AND THAT IN THE COURSE OF THIS ACTIVITY THEY MAY GET BITTEN.

WHILE THE STAFF OF COMPANION ANIMAL HOSPITAL MAKES EVERY EFFORT TO DISCOURAGE AGGRESSIVE BEHAVIOR, WE MUST POINT OUT THAT OCCASIONAL INCIDENT OF BITES ARE UNAVOIDABLE. I AGREE TO HOLD COMPANION ANIMAL HOSPITAL, IT'S AGENTS AND OTHER PET OWNERS HARMLESS IN INCIDENTS OF ACCIDENTAL INJURY.

SIGNED:_____ **DATE:**_____