

Brees Animal Hospital
7436 Frankford Avenue
Philadelphia, Pa 19136
215-338-3219

Client's Name (First, Last) _____

Pet's Name _____

Address _____

City, State, Zip _____

Phone Number (home) _____ (Cell) _____

Emergency Contact Person _____

Emergency Contact Number _____

Dog / Cat _____

Breed _____

Age _____

Gender _____

Color _____

Boarding Dates: Drop off Date _____ Pick up Date _____

Is your pet on:

Special Diet? Own food? Brand _____

Feeding Instructions _____

Medication? Type and Dosage _____

Would your Cat or Dog show any Aggression towards:

Cage Confinement _____ Other Animals _____

Food Handling _____ Kennel Staff (strangers) _____

Does your pet have any allergies towards Certain Foods? _____

Allergies towards Medications? _____

Does your pet get Diarrhea or stomach upsets with Diet changes? _____

BATH: By Signing, I authorize Bree's Animal Hospital to bathe my pet prior to Pickup for an additional cost of \$25.

x _____ Initial if declined x _____

AUTHORIZATION FOR MEDICAL TREATMENT WHILE BOARDING AT BREE'S ANIMAL HOSPITAL

I, the Undersigned Owner of the Patient above, hereby authorize Bree's Animal Hospital to administer such treatment as is necessary if my above mentioned pet was to become ill while boarding at Bree's Animal Hospital and all attempts to contact me have been tried and proven unsuccessful. Further, I assume Financial Responsibility for the treatment if an illness was to arise. As requested, I have supplied the above Emergency Contact information. I, hereby, certify that I have read and fully understand this 'Authorization for medical treatment while boarding' Form.

Owner / Responsible Agent x _____ date _____

Witness x _____ date _____