



# My Pet's Place – Boarding/Daycare Consent Form



Client : \_\_\_\_\_

Patient: \_\_\_\_\_

**ALL GUESTS ADMITTED TO THE HOSPITAL MUST BE CURRENT ON THE FOLLOWING VACCINES:**

DOGS: DAPP, Leptospirosis, Bordetella, Rabies, Canine Influenza, and Negative Fecal

If proof of vaccines can't be verified, we will be required to vaccinate your pet, at your expense. This is done to protect your pet, our staff, and other client(s) pet(s). I understand if my pet has not completed the entire series of a vaccination, there is a risk for contracting diseases such as Distemper, Parvovirus, Leptospirosis, Bordetella, and Influenza. In addition, for the best level of protection, all initial vaccines should be provided at least 10 days in advance of a reservation: \_\_\_\_\_ (Initial)

Off Leash Authorization

I authorize the pet listed on this document to be off leash during exercise sessions and/or enrichments services. I understand that off leash time is intended to be restricted to designated areas that have barriers for containment; however, the chance for escape is higher for a pet being off leash. \_\_\_\_\_ (Initial)

Group Playtime Authorization

Any dog participating in group playtime must complete and pass the assessment process. In the event, the process has been completed and the dog has been deemed as appropriate to participate; My Pets Place manages all play groups to minimize the risk of bites or fights. I acknowledge that my dog is at potential risk of injury due to participation in group playtime. \_\_\_\_\_ (Initial)

**CONSENT FOR ADMISSION TO HOSPITAL**

I authorize the veterinarian(s) on duty (and the assistants they designate) to examine the pet(s) and to administer medical treatment or emergency surgical treatment which is considered therapeutically and/or diagnostically necessary on the basis of the findings during the course of the examination. I hereby consent to and authorize the performance of such procedure(s) as are deemed necessary and desirable in the exercise of the veterinarian's professional judgment. I further understand that any animal found to be infected with either external or internal parasites will be treated at my expense.

I understand that the treatment of the patient will be conducted with due care and in accordance with the prevailing standards of competency in Veterinary Medicine. I certify that no guarantee or assurance has been made as to the results that may be obtained through the course of treatment undertaken by the veterinarians, or employees of My Pet's Vet and/or My Pet's Place.

I assume financial responsibility for all charges incurred to the patient for services rendered and understand that full payment is required upon discharge. In case of non-payment, I am aware that My Pet's Vet and/or My Pet's Place will charge the cost of the collection debt on the amount owed for services. I understand that a written estimate of charges is available within reasonable time at my request. I also consent to the release of medical information.

Diarrhea/Loose Stool

Diarrhea or loose stool is not uncommon for pets exhibiting stress outside of the normal routine such as boarding, daycare, and/or diet change. I authorize consent for the pet listed on this form, to receive treatment if he/she has diarrhea/loose stool. I understand that additional charges may be incurred in doing so.

**ADVANCED DIRECTIVE**

In the event my pet has a medical emergency or condition requiring treatment, care will be provided to stabilize my pet first. Upon stabilization, I acknowledge that all efforts will be made to reach me or my assigned representative for treatment authorization deemed necessary by a veterinarian of My Pet's Vet; however, if I cannot be reached:

**Please initial one option**

- \_\_\_\_\_ I authorize ANY and ALL TREATMENT deemed necessary by the veterinarian
- \_\_\_\_\_ I authorize necessary treatment up to \$\_\_\_\_\_
- \_\_\_\_\_ I authorize no treatment beyond, emergency care, until I have been reached
- \_\_\_\_\_ I authorize NO TREATMENT WITHOUT VERBAL CONSENT FIRST

Signature: \_\_\_\_\_ Phone #: \_\_\_\_\_ Date: \_\_\_\_\_

Secondary Contact (if applicable): Name: \_\_\_\_\_ Phone #: \_\_\_\_\_