Emergency Contact:

Please list the name & number where you or your designated agent can be reached in case of an emergency.

NAME: _____/ NUMBER_____

In the event of an emergency where the hospital is unable to contact me,
I authorize Animal Medical Center to provide any necessary Medical care to save the life ____of or maintain the life ____of my pet.

In the event that a situation arises where your pet(s) require NON-Emergency medical attention please indicate your preference below

☐ CALL ME FIRST, BEFORE ANY TREATMENT IS GIVEN I CAN BE REACHED AT THIS NUMBER _____

☐ CALL ME AFTER TREATMENT HAS BEEN GIVEN

☐ DO NOT CALL ME, TREAT MY PET AS NEEDED AND ADVISE ME AT TIME OF PICK UP

Please be aware that the comfort and safety of pets in our care is our number one priority. The Staff at Animal Medical Center of Mt. Washington will NOT refuse or withhold treatment to any pet that is in pain or discomfort based on owner availability at the time treatment is deemed necessary by our Veterinary Staff. All charges for minimal treatment are the owner's responsibility and must be paid in full at the time of discharge.

Please sign below to indicate that you agree with these boarding requirements

_____
Owner or Authorized Agent Signature

List below any pre-existing conditions that we should be aware of:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____

Pet: _____
Owner: _____
Admission Date: _____
Discharge Date: _____

DIET
MEDS
BATH
PEDICURE

Weight IN _____ Weight OUT _____

Regular ☐ On Meds ☐ Geriatric ☐

DATE	APPT	BM	URIN	VOM	INITIALS