BOARDER CHECK IN

All vaccinations must be current & pets must be free of parasites. A fecal must have been done within the last year. We will examine for external parasites upon arrival. Treatment will be at owner's expense.

Today's Date_____ Pet Name_____ Owner Name_____
Check Out Date_____AM or PM Breed/Color_____
(Circle One)

**********WE WOULD APPRECIATE YOU PICKING UP YOUR PET AFTER 10:00AM********

Pet Has The Following Items. (Check All That Apply)

_____Toy or Blanket Quantity_____ Description_____
_____Treats _____
_____**Has Own Food or** _____**Feed Hospital Food**
Amount: _____Cups _____ Times a Day
_____**Medications Quantity**_____

1.) _____ (Name) _____ (Dosage) **2.)** _____ (Name) _____ (Dosage)

3.) _____ (Name) _____ (Dosage) **4.)** _____ (Name) _____ (Dosage)

Needs These Vaccinations or Services:

_____Bordatella (KC) _____DHPP/DHLPP _____Heartworm Test _____Fecal _____RV
_____FVRCP _____FELV _____Other_____
_____Bath (To Be Given On) _____ _____Med. Bath (Shampoo) _____
Emergency Phone No. & Contact Person_____
_____Treat As Needed Cost Limit_____

**********FOR HOSPITAL USE ONLY**********

Location of Pet_____

	Answer: Y (yes) N (no) A (abnormal)									**Food Used** Date	Code
Date	____	____	____	____	____	____	____	____	____	_____	_____
Eating	____	____	____	____	____	____	____	____	____	_____	_____
Drinking	____	____	____	____	____	____	____	____	____	_____	_____
B/M	____	____	____	____	____	____	____	____	____	_____	_____
Urine	____	____	____	____	____	____	____	____	____	_____	_____
Vomiting	____	____	____	____	____	____	____	____	____	_____	_____
Diarrhea	____	____	____	____	____	____	____	____	____	_____	_____
Coughing	____	____	____	____	____	____	____	____	____	_____	_____
Limping	____	____	____	____	____	____	____	____	____	_____	_____
Itching	____	____	____	____	____	____	____	____	____	_____	_____
Aggressive	____	____	____	____	____	____	____	____	____	_____	_____
Date	____	____	____	____	____	____	____	____	____	_____	_____
Eating	____	____	____	____	____	____	____	____	____	_____	_____
Drinking	____	____	____	____	____	____	____	____	____	_____	_____
B/M	____	____	____	____	____	____	____	____	____	_____	_____
Urine	____	____	____	____	____	____	____	____	____	_____	_____
Vomiting	____	____	____	____	____	____	____	____	____	_____	_____
Diarrhea	____	____	____	____	____	____	____	____	____	_____	_____
Coughing	____	____	____	____	____	____	____	____	____	_____	_____
Limping	____	____	____	____	____	____	____	____	____	_____	_____
Itching	____	____	____	____	____	____	____	____	____	_____	_____
Aggressive	____	____	____	____	____	____	____	____	____	_____	_____