



**Pet Hotel Check-In Consent Form**

**OWNER'S NAME:** \_\_\_\_\_ **PET'S NAME:** \_\_\_\_\_  
**SEX:** \_\_\_\_\_ **BREED AND COLOR:** \_\_\_\_\_  
**CHECK-IN DATE:** \_\_\_\_\_ **CHECK-OUT DATE:** \_\_\_\_\_ **CHECK-OUT TIME:** \_\_\_\_\_  
**\*\* Check-out time is after 8:30am and during normal business hours only. \*\***  
 Pets are released to owners only, unless authorized here. Please be sure they are aware that payment is due at discharge.  
 Person(s) authorized to pick up my pets: \_\_\_\_\_

**CONTACT INFORMATION WHILE YOU ARE AWAY:**

Primary Phone #: \_\_\_\_\_ Cell Phone #: \_\_\_\_\_ Other Phone #: \_\_\_\_\_  
 If I cannot be reached, the person authorized to make medical decisions on my behalf: \_\_\_\_\_  
 Their Phone #: \_\_\_\_\_ Cell Phone #: \_\_\_\_\_ Work Phone #: \_\_\_\_\_

**DIETARY NEEDS:**

I brought food for my pet: YES NO If YES, type and amount: \_\_\_\_\_  
 FEEDING INSTRUCTIONS: \_\_\_\_\_

**MEDICATION:**

\*\* There is a small additional fee for administering medications. \*\*

Medication	Amount	Frequency

**Does your pet have:** (circle all that apply) A tendency to chew objects? Separation anxiety? Storm Phobia?  
 Fireworks Phobia? Cage anxiety? Dog/Cat aggression? Other: \_\_\_\_\_

**LIST BELONGINGS: \*\* The hospital is not responsible for any lost or damaged belongings. \*\***  
 \_\_\_\_\_  
 \_\_\_\_\_

**Initial any other services desired while your pet is here:**  
**Bath before going home** \_\_\_\_\_ (please allow extra time for bathing and drying before picking up your pet)  
**\*\* If your pet soils itself while boarding, a bath will be given and the fee added to your invoice. \*\***  
 Nail Trim \_\_\_\_\_ Express Anal Glands \_\_\_\_\_ Exam \_\_\_\_\_ Vaccines \_\_\_\_\_ Teeth Cleaning \_\_\_\_\_  
 Spay/Neuter \_\_\_\_\_ Heartworm/Fecal Check \_\_\_\_\_ Lab Work \_\_\_\_\_ Other: \_\_\_\_\_

*I am the owner or agent of the pet described above and have the authority to execute this consent. I understand that Animal Family Practice requires my pet to be free from internal and external parasites and requires proof that a veterinarian administered a Rabies and Distemper combination vaccine within the last year and a Bordetella vaccine within the last six months. I understand that I am financially responsible for all costs for the care of my pet including vaccination or parasite treatment and that this payment is due upon discharge. Should any medical issues arise, the veterinarians and staff at Animal Family Practice will attempt to contact me at the telephone numbers provided above. In the event I can't be contacted, I understand that the appropriate treatment will be given to my pet and I assume financial responsibility for this care. I have read and understand this consent.*

**RESPONSIBLE PARTY SIGNATURE:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
**WITNESS:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
 If needed, please list any additional information or instructions on the back of this sheet.