Suttons Bay Animal Hospital Boarding Check-in Sheet

Patient Name: _____**Client Name:** _____**Boarding Dates:**_____

Food:

AM -_____ Noon - _____

PM – _____ Hospital Food - ____Own Food - ___ Brand - _____

We are happy to provide your dog with our hospital food (for sensitive stomachs), at no additional charge, if your dog or cat is not on a special diet

Belongings:

Treats: _____

Leash: Yes____ No____Color_____

Collar: Yes____ No____ Color_____

Bedding: Yes____ No____ Color_____

Toys: Yes____ No____ Description_____

Other: _____

Medications: please list below the medications your pet currently takes. When admitting your pet for boarding, please allow 20 minutes for check in. One of our veterinary assistants will go over your animal's medication administration.

Medication:_____**Medication:**_____

Medication:_____**Medication:**_____

Medication:_____**Medication:**_____

Medication:_____**Medication:**_____

Please read below and initial the applicable line:

*If my pet will not eat the food I have provided, or the hospital dry food, I authorize the hospital to provide a canned diet. In this case additional fees for food will be added. I give permission: _____ Please contact me prior to enticing my pet with wet food: _____

*If my pet has a simple gastro-intestinal disturbance (diarrhea, vomiting), I authorize medical management with diet and medication without contacting me. If symptoms are severe or non-responsive I understand the clinic will contact me to authorize further testing and treatment.
I give permission: _____ Please contact me prior to treatment: _____

All dogs must be up to date on Rabies, Distemper and Bordetella vaccines. If you are not a current client, please bring along proof of vaccines, or have them sent over ahead of time. Fax: 231-271-4635 Email: sbah@suttonsbayanimalhospital.com

We check for fleas on every patient that enters our facility. As diligent as we are, there are rare instances where fleas are found on a patient within our boarding population. If this occurs, we will apply or administer a non toxic medication to your pet to keep flea control a top priority.

Client signature:_____**Date:**_____

For hospital use only:

Client account number:_____ UTD on vaccines:_____ Appointment scheduled:_____

Kennel assistant checking in:_____ Receptionist checking in:_____ Assistant checking in:_____

Notes:_____