

Care Animal Hospital
Patient Boarding Check-In Form

Owner/Client Name: _____
 Address: _____
 City: _____ Zip code: _____
 Phone : _____ Cell: _____

Patient Information

Pet's Name: _____ Age: _____
 Breed: _____
 Sex: _____ Spayed/Neutered: _____
 Date and place of last vaccinations: _____

All boarding animals must be current on all vaccinations and free of parasites like fleas and ticks or they will be treated at the owner's expense.

Date In:	Date Out:
Bath: Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, please call before coming to make sure your pet is dry	Nails/anal's with bath: Yes <input type="checkbox"/> No <input type="checkbox"/>
Belongings:	Feeding instructions:
Emergency contact #:	Medications:

Other Instructions: _____

Client Signature _____ **Date** _____