

Animal and Bird Clinic of Mission Viejo

24912 Chrisanta Drive • Mission Viejo, CA 92691 • (949) 768-3651 • FAX (949) 768-1333

CANINE BOARDING FORM

Client: _____ # _____ Patient: _____ Date: _____

Number where you or designated agent can be reached in case of an emergency: () _____

Weight: _____ Temperature: _____ Age: _____ Sex: F FS M MN

Pick Up Date: _____ Time: _____ am pm

- Doctor Exam: Yes No Please Check: _____
- Boosters: DHPPC Bordetella Rabies Lyme Current
- Boarder Bath: Yes No Nail Trim: Yes No
- Diet: Eukanuba: Yes No Special: Yes No Instructions: _____

- Medication to be given while boarding: _____
 - _____ Last Given _____ times per day _____ am _____ pm
 - _____ Last Given _____ times per day _____ am _____ pm
 - _____ Last Given _____ times per day _____ am _____ pm

• Property: _____

• Nightly rate: _____

If tranquilizers are necessary for treatment or handling, I give my permission to the Animal & Bird Clinic to administer such medications. All animals entering the hospital must be up to date on vaccinations and free of external parasites (fleas, ticks, etc.) or they will be treated upon entry (fees will apply). I also authorize the Animal & Bird Clinic to do whatever is necessary should an emergency situation arise. Payment is required when animal(s) are released. Pets are released only during regular clinic hours. If I neglect to pick up my pet(s) within 5 days of the date above, you may assume that the pet is abandoned and you are hereby authorized to discharge the pet as you deem best and necessary.

Signed: _____ Date: _____ Admitted By: _____

TO BE FILLED OUT BY DOCTOR/TECHNICIAN

- | | | |
|--|---|---|
| <p>1. ATTITUDE :
 <input type="checkbox"/> Normal/Alert <input type="checkbox"/> Other _____</p> <p>2. HYDRATION:
 <input type="checkbox"/> Normal <input type="checkbox"/> Other _____</p> <p>3. COAT & SKIN:
 <input type="checkbox"/> Normal <input type="checkbox"/> Oily <input type="checkbox"/> Itchy <input type="checkbox"/> Dull
 <input type="checkbox"/> Shedding <input type="checkbox"/> Scaly <input type="checkbox"/> Matted <input type="checkbox"/> Dry
 <input type="checkbox"/> Parasites <input type="checkbox"/> Tumors
 <input type="checkbox"/> Other _____</p> <p>4. EYES:
 <input type="checkbox"/> Normal <input type="checkbox"/> Discharge <input type="checkbox"/> Infection
 <input type="checkbox"/> Inflamed <input type="checkbox"/> Cataract <input type="checkbox"/> Deformities
 <input type="checkbox"/> Other _____</p> <p>5. EARS:
 <input type="checkbox"/> Normal <input type="checkbox"/> Mites <input type="checkbox"/> Inflamed
 <input type="checkbox"/> Itchy <input type="checkbox"/> Excessive Hair <input type="checkbox"/> Tumor
 <input type="checkbox"/> Other _____</p> <p>6. NOSE & THROAT:
 <input type="checkbox"/> Normal <input type="checkbox"/> Discharge <input type="checkbox"/> Infl. Tonsils
 <input type="checkbox"/> Infl. Throat <input type="checkbox"/> Enlarged Lymph Gland
 <input type="checkbox"/> Other _____</p> | <p>7. MOUTH, TEETH, GUMS:
 <input type="checkbox"/> Normal <input type="checkbox"/> Infl. Lips <input type="checkbox"/> Loose Tooth
 <input type="checkbox"/> Tartar <input type="checkbox"/> Broken Teeth <input type="checkbox"/> Pyorrhea
 <input type="checkbox"/> Gingivitis <input type="checkbox"/> Tumors
 <input type="checkbox"/> Other _____</p> <p>8. LEGS & PAWS:
 <input type="checkbox"/> Normal <input type="checkbox"/> Joint Prob. <input type="checkbox"/> Lameness
 <input type="checkbox"/> Nail Prob. <input type="checkbox"/> Damaged Ligaments
 <input type="checkbox"/> Other _____</p> <p>9. WEIGHT:
 <input type="checkbox"/> Normal <input type="checkbox"/> Over by: _____
 <input type="checkbox"/> Under by: _____ <input type="checkbox"/> Other _____</p> <p>10. HEART:
 <input type="checkbox"/> Normal <input type="checkbox"/> Slow <input type="checkbox"/> Fast
 <input type="checkbox"/> Murmur <input type="checkbox"/> Other _____</p> <p>11. LUNGS:
 <input type="checkbox"/> Normal <input type="checkbox"/> Breathing Difficulty <input type="checkbox"/> Congestion
 <input type="checkbox"/> Coughing <input type="checkbox"/> Abnormal Sound <input type="checkbox"/> Rapid Resp.
 <input type="checkbox"/> Other _____</p> | <p>12. ABDOMEN:
 <input type="checkbox"/> Normal <input type="checkbox"/> Mass <input type="checkbox"/> Tense/Painful
 <input type="checkbox"/> Enlarged Organs <input type="checkbox"/> Fluid
 <input type="checkbox"/> Other _____</p> <p>13. GASTROINTES. SYSTEM:
 <input type="checkbox"/> Normal <input type="checkbox"/> Abn. Feces <input type="checkbox"/> Vomit
 <input type="checkbox"/> Gas <input type="checkbox"/> Parasites <input type="checkbox"/> Anorexia
 <input type="checkbox"/> Other _____</p> <p>14. UROGENITAL SYSTEM:
 <input type="checkbox"/> Normal <input type="checkbox"/> Enlarged Prostate
 <input type="checkbox"/> Mammary Tumors <input type="checkbox"/> Abn. Urination
 <input type="checkbox"/> Genital Discharge <input type="checkbox"/> Abn. Testicles
 <input type="checkbox"/> Other _____</p> <p>15. LYMPH, TONSILS, THYROID:
 <input type="checkbox"/> Normal <input type="checkbox"/> Other _____</p> <p>16. CNTRL. NERVOUS SYSTEM:
 <input type="checkbox"/> Normal <input type="checkbox"/> Abscessed <input type="checkbox"/> Infected
 <input type="checkbox"/> Full <input type="checkbox"/> Other _____</p> <p>17. ANAL SACS
 <input type="checkbox"/> Normal <input type="checkbox"/> Abscessed <input type="checkbox"/> Infected
 <input type="checkbox"/> Full <input type="checkbox"/> Other _____</p> |
|--|---|---|

DESCRIPTION (Use same numbers as above for corresponding descriptions below.)

Examined By: _____