Southwest Pet Hospital

1202 Henryetta Street, Springdale AR 72762 479-751-5601

Office Use Only:
Rec: _____ DVM/N:_____ KA_____
Check-in: _____ Check-out:_____

BOARDING CHECK-IN AND AUTHORIZATON

Client's Name: _____ **Check In Date** _____

Pet's Name(s): _____ **Expected Check Out Date** _____ ☐ **Before 1:00PM** ☐ **After 1:00 PM**

1. ☐ My pet is current on vaccinations per hospital protocol. If vaccines were administered by another veterinarian, I am responsible for providing documentation prior to boarding check-in; otherwise vaccines will be re-administered at my expense.
   ☐ Please update my pet's vaccinations and wellness examination at my expense to meet hospital protocols.

2. ☐ My pet been treated with an approved Flea & Tick prevention. Product:_____ Date applied:_____.
   An approved product will be applied at my expense 30 days after the date above if my pet is boarding at that time.
   ☐ My pet has not had an approved Flea & Tick Prevention, please administer to my pet at my expense.

3. ☐ I am leaving the following personal belongings described.
   ☐ No, I am not leaving any belongings.

Belongings ☐ Collar ☐ Leash ☐ Blanket / Bed ☐ Dish(s) ☐ Carrier ☐ Food ☐ Medications ☐ Toys ☐ Treats ☐ Other:

4. ☐ Please feed my pet in clinic dry kibble while boarding (included with boarding).
   ☐ I will provide my pet's regular food to be fed while boarding. Food:_____ Feed_____ cups _____times/day.
   ☐ My pet requres a Prescription or Canned Food diet. Please provide the food following food at my expense: _____

5. Please provide the following Grooming Services for my pet at my expense. Ask for estimates.
   ☐ Grooming Services as I have scheduled in advance (Cost start at $_____).
   ☐ Bath and brush (Cost start at $_____, increases based on weight.)
   ☐ Other: ☐ Pedicure ☐ Nail Dremel ☐ Clean ears ☐ Express Anal Glands ☐ Brush / Blowout ☐ Deshedding Treatment
   ☐ No, I decline grooming services for my pet.

Office Use Only for Grooming Appt
Date_____
$_____

6. ☐ Please medicate my pet while boarding
7. ☐ Please refill my pet's medications: _____
   ☐ No, my pet is not on medications.

Medication: _____ given _____ times/day
_____ given _____ times/day
_____ given _____ times/day
_____ given _____ times/day

8. Please provide the following services / procedures for my pet.
   ☐ Please call me with an estimate before providing treatment.
   ☐ No, my pet does not need any other services.

Services: ☐ Spay/Neuter ☐ Dental Cleaning ☐ Microchip Implant ☐ Wellness Exam/ Vaccines ☐ Bloodwork ☐ Urinalysis ☐ Radiographs
Please Check: ☐ Allergies / Skin ☐ Ears ☐ Arthritis / lameness ☐ Weight ☐ Other:

I am aware of and understand Southwest Pet Hospital policies including, but not limited to:

- **Check out time is at 1PM. I will be charged for an additional day of boarding if I pick up my pet after 1PM.**
- **I also understand that Premium Boarding Rates may apply to boarding reservations surrounding major holidays.**
- **No Flea/Tick Policy – treatment will be at my expense**
- **Necessary symptomatic medical treatment (i.e. diarrhea medication, etc.) of my pet while boarding will be at my expense.**
- **Southwest Pet Hospital is not responsible for lost belongings.**
- **The staff is not on the premises 24 hours a day.**

If an emergency arises, I authorize the doctors at Southwest Pet Hospital to perform the necessary procedures. I understand that they will try to contact my emergency contact in the case of an emergency at the number given below prior to treatment. I understand that I will be responsible for these charges.

_____ _____ _____
Signature of Owner / Authorized Agent ***Emergency Contact & Phone # (Mandatory)*** ***Date***