

Kettle Moraine Veterinary Clinic

2712 Eastern Avenue P.O. Box 439*Plymouth, WI 53042*(920)8924225 Fax (920)892-2643

First Name:

Last Name:

Mailing Address:

City:

State:

Zip Code:

Home Phone:

Cell Phone:

Work Phone:

E-mail:

Employer:

Additional Owners:

Agent Information

Yes No Other than you and any additional owner(s) listed above, are there any other person(s) you would give primary responsibility for the care of the patient?

If you have checked "Yes" above, please list the name, telephone number, and address for the person(s) in the order you wish for us to contact them in the event that you or the co-owner(s) is not available (all authorized agents must be 18 years of age).

1. Name: _____ Phone: _____

Address: _____

2. Name: _____ Phone: _____

Address: _____

I understand that my veterinarian will need to communicate with me, or someone designated by me, prior to treatment of my pet(s) in order to obtain informed consent. For purposes of obtaining informed consent, I direct my veterinarian as follows:

Informed consent may ONLY be provided by me: Yes _____ No _____

Informed consent may be provided by owner(s) and/or agent(s) above: Yes _____ No _____

(This included authorizing all medications, treatments, hospitalizations, sedation, anesthesia, surgery, and euthanasia. **The authorized agent will be responsible for all incurred costs.**)

Signature

Printed Name

Date

Witness Signature (Office Personnel)

Printed Name

Date
