

# Animal Medical Center

25 W. Third Avenue  
 Trappe, PA 19426  
 610-489-8982  
 www.mypetdoc.com

## Drop Off Examination Consent Form

(Please complete form in its entirety)

Date: \_\_\_\_\_

Name: \_\_\_\_\_ Emergency Contact

Phone: \_\_\_\_\_

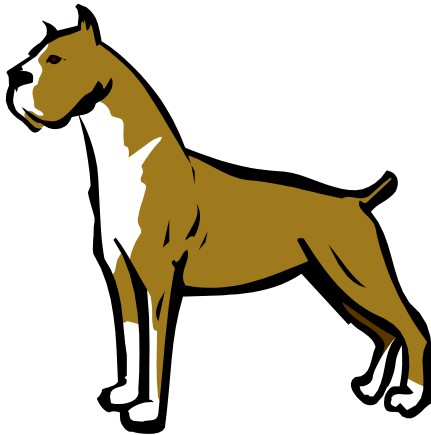
Alternate Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Pet's Name: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M F

Please give us a history of what signs & symptoms your animal has displayed, any extra treatment you would like done for your pet while they are with us today (nail trim, ear clean, flea & tick treatment, vaccinations, microchip, bath)?

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_



Please circle area(s) of concern



	Yes	No
Have you noticed any change in your pet's water consumption? If so, please describe:		
Have you noticed any change in your pet's appetite? If so, please describe:		
Have you noticed any change in your pet's urinary habits? If so, please describe:		
Have you noticed any change in your pet's bowel movements? If so, please describe:		
Have you noticed any change in your pet's behavior/activity? If so, please describe:		

<b>Have you noticed any vomiting/diarrhea/coughing/sneezing? If so, please describe:</b>		
<b>Is your pet receiving heartworm/flea/tick preventive medications? If so, give name of product and when the last dose was given:</b>		

Pet's Name: \_\_\_\_\_

Consent for examination and/or treatment.

By signing below, I hereby authorize the doctors and staff of the Animal Medical Center to examine my pet. I also understand that if my pet has symptoms including sneezing, coughing, vomiting and/or diarrhea my pet will be placed in isolation so they will not expose other hospitalized animals and additional charges will be applied.

In case of an emergency, I authorize the doctors and staff of the Animal Medical Center to administer life saving emergency care as needed until I can be contacted. I understand that I will be responsible for any and all emergency treatment fees. If an emergency situation should arise and I cannot be contacted at the numbers provided...

- I authorize the doctors and staff at Animal Medical Center to proceed with emergency treatment not to exceed \_\_\_\_\_ (dollar amount) over the current estimate.
- I authorize the doctors and staff at Animal Medical Center to proceed with any life saving services necessary at any cost to me.
- I DO NOT wish the doctors and staff at Animal Medical Center provide life saving treatment in an emergency situation.

\*Must be 18yrs or older and legal guardian to sign consent form.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name: \_\_\_\_\_