Rock Bridge Animal Hospital BOARDING AGREEMENT

5095 S. Providence Rd - Columbia, MO 65203
Phone (573) 443-4501 Fax (573) 443-2508

Name:	Pet's Name:
Address:	Species:
	Breed:
	Color:

Any vaccines not current must be given upon arrival for boarding

Written proof of vaccinations or verification with a veterinarian must be provided prior to boarding.

Vaccines current? (DAPP, RV, Bord for Dogs; FvRCP, RV for cats) q Yes q No Staff Init._____

Please initial giving permission to perform the following (Cross out declined services):

_____ _____ _____ _____

_____ _____ _____ _____

Yes No Own food: _____ Quantity/day _____

Yes No Medications required? _____

There will be an additional fee of $1.13/day for administering oral or topical medication and $5.53/day for injections

Yes No Would you like your pet to receive a bath, ear cleaning and nail trim for $31.62?
(After 7 nights of boarding your pet will receive a complimentary bath – nail trims excluded)

Yes No Would you like us to call you if we notice a NON-emergency medical condition?
If no, you approve treatment for minor urgent conditions, such as diarrhea, limping or wounds up to ___$50 ___$100 ____$_____ prior to contacting, ____Treat regardless of expense, ___ Call 1st

List personal belongings: _____

Emergency Contact _____ Phone _____

If parasites are found on your pet during the stay, they will be treated as deemed appropriate by the veterinarian, and the cost of the treatment will be added to the total bill.

****Prior arrangements will need to be made should someone else need to pick up the pet****

Yes No I give permission for my pet to be picked up by _____

Pick up date & time:_____ AM/PM **We are closed from 12-2 pm on Wed.**

Reasonable precaution will be used against injury, escape, or death of this pet. The clinic and staff will not be held liable for problems that develop provided reasonable care and precautions are followed. I understand that any problem that develops with my pet will be treated as deemed best by the staff veterinarians and I assume full responsibility for the treatment expense involved.

Responsible party _____ Date _____

Staff member _____ Date _____

Flea check _____ Staff Init. _____