Milan Area Animal Hospital
517 West Main Street
Milan, Michigan 48160
PH: 734- 439-CARE (2273)

Office Use ONLY
Checked in by _____
Estimate given _____
Pick Up time _____

Day Care Form

Thank you for giving us the opportunity to care for your pet.

Owner Name: _____ Pet Name _____

Contact Phone: _____ Alternate Phone: _____

Reason for visit: _____

Is your pet eating /drinking normally? ☐ Yes ☐ No (*if no explain*): _____

What is your pets normal diet? _____

Is your pet experiencing any of the following *(check all that apply)*?

☐ Vomiting ☐ Diarrhea ☐ Coughing ☐ Sneezing

☐ Lethargy ☐ New lumps/bumps/oddities ☐ Itching (*where* _____)

If yes - for how long? _____

Any other concerns? _____

_____

I would like to update the following on my pet (*check all that apply*):

Please feel free to ask for explanation or help with what your pet is due for.

CANINE
☐ Rabies (required by law)
☐ DA2PPv-C (*Puppy 5-way Distemper*)
☐ DA2PPv-L (*Adult 5-way Distemper)*
☐ Bordetella (*cold virus*)
☐ Lyme (*spread by ticks*)
☐ CIV (*canine influenza*)
☐ Proheart (6 *month heartworm prevention*)

FELINE
☐ Rabies
☐ RCPC w/Leukemia

ALL SPECIES
☐ Yearly blood work/panel *(to check internal organ function, sugar levels, cholesterol, etc)*
☐ Heartworm & tick borne diseases test
☐ Fecal *(check for intestinal parasites)*

☐ **PLEASE UPDATE EVERYTING DUE**

I hereby authorize the veterinarian at Milan Area Animal Hospital to examine, treat and prescribe for the above described pet(s). I agree to assume responsibility for all charges incurred in the care of this animal. I understand that all charges incurred in the treatment of my pet will be paid in full at the time of discharge and that Milan Area Animal Hospital does not bill or offer payment plans.

I have read, understand and agree with the above information.

Signature: _____ Date: _____