MDPETCARE™ LOW COST CLINIC

Feline Vaccination Form

Microchip Sticker

OFFICE USE ONLY			
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MDPetCare 30 N 40th Place, Phoenix, Arizona 85034 Phone: (602) 358-7267

Date: _____ Name (Last, First): _____

Address: _____ City: _____ State: _____ Zip: _____

Email Address: _____

Phone Number: _____ ☐ Home ☐ Cell ☐ Work

Pet's Name: _____

Age: _____ ☐weeks ☐ months ☐ years

Breed: _____

Color/Markings: _____

Sex:
☐ Male – Not Neutered ☐ Male – Neutered
☐ Female – Not Spayed ☐ Female - Spayed
☐Unknown

To the best of your knowledge, has your pet ever had a vaccine reaction? ☐ Yes ☐ No
Has your pet shown any signs of illness in the last 3 days (vomiting, diarrhea, lethargy, etc)? ☐ Yes ☐ No

REQUESTED VACCINATIONS/MICROCHIP:
☐ Rabies (must be greater than 12 weeks) ☐ Feline Distemper (FVRCP) ☐ Feline Leukemia*
☐ Microchip **proof of current negative FeLV test required for vaccine*

CONSENT FOR VACCINATION(S) AND PAYMENT OF SERVICES:

My signature below attests that I am the legal owner/authorized representative of the described pet and I authorize the staff of MDPetCare, volunteers, representatives, or agents to administer vaccinations to said pet, including rabies. I am at least 18 years of age. I understand and acknowledge that MDPetCare uses modern techniques and trained staff in the care of my pet and that reasonable precautions are used to prevent injury, escape, or destruction of said pet/animal. I understand that the physical examination that the veterinarian will conduct on my pet today is to determine the suitability of administering vaccinations today, and that this exam is not to replace the recommended yearly exam of my pet. I understand that the veterinarian cannot address medical issues unrelated to the administration of vaccines at this time. **To my knowledge, my pet has not previously had any adverse reaction to a vaccine or medication. I understand and acknowledge that an adverse reaction to a vaccine may occur that may require medical intervention by the site veterinarian.** If further medical treatment is indicated, I acknowledge that I am responsible for transporting my pet, immediately, to a private veterinary clinic. I understand and acknowledge that, should vaccines be administered, it is the professional opinion of the attending veterinarian that my pet is an acceptable candidate for vaccinations. I understand that the attending veterinarian may refuse to perform any procedure on my pet that may reduce or terminate the quality of life for my pet. I agree on behalf of self, other agents and successors, personal representatives and executors, to indemnify and hold harmless MDPetCare, its officers, employees and agents from all losses, suits, damages or costs arising from the care, treatment, transport and surgery of my pet including, but not limited to personal injury, damage to property, pets or costs and fees incurred in the health and care of my pet. I assume all financial responsibility for all charges incurred and I understand that all fees are due at the time services are rendered. I have fully read and understand the above conditions.

Owner Signature: _____ **Date:** _____

DO NOT WRITE BELOW THIS LINE – FOR MDPETCARE STAFF ONLY

Weight: _____lbs Temp: _____°F Pulse: _____bpm Resp: _____bpm MM/CRT: _____

General Appearance ☐WNL ☐ABN ☐NE	Oral Cavity/Teeth ☐WNL ☐ABN ☐NE ☐Dental Calculus	Mucous Membranes ☐WNL ☐ABN ☐NE	Eyes ☐WNL ☐ABN ☐NE
Ears ☐WNL ☐ABN ☐NE	Heart ☐WNL ☐ABN ☐NE ☐Heart murmur	Respiratory ☐WNL ☐ABN ☐NE	Abdomen ☐WNL ☐ABN ☐NE
Musculoskeletal ☐WNL ☐ABN ☐NE	Lymph Nodes ☐WNL ☐ABN ☐NE ☐Enlarged LN	Genitourinary ☐WNL ☐ABN ☐NE	Integumentary ☐WNL ☐ABN ☐NE

EXAM NOTES/FINDINGS: _____

_____

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VACCINES GIVEN:		
☐ FVRCP (RF SQ)	4wk / 1yr / 3yr	**RABIES (RH SQ)** ☐1YR ☐3YR
☐ FELV (LH SQ)	4wk / 1yr	*Rabies Sticker on white copy*

_____
Doctor Signature

CA RB MG NG SP KV KS