All Valley Pet Hospital

230 East Betteravia Suite A

Santa Maria, CA 93454

(805) 922-0305

Medical Authorization Form

Date: _____/_____/_____

Owner Name:_____

Pet's Name:_____

PHONE NUMBER WHERE YOU CAN BE REACHED **TODAY**:_____

ALTERNATE PHONE NUMBER(S):_____

Species: CANINE_____ FELINE_____

When is the last time your pet ate/drank water:_____

Reason for Visit/Health Complaint:

_____

_____

_____

Previous Illness:_____

Allergies:_____

Current Medication(s):

_____

CONSENT FOR TREATMENT:

I CERTIFY THAT I AM THE LEGAL OWNER OR AUTHORIZED AGENT FOR THE OWNER OF THE ANIMAL DESCRIBED ABOVE. I AUTHORIZE THE DOCTOR(S), STAFF, OR REPRESENTATIVES OF ALL VALLEY PET HOSPITAL TO EXAMINE AND PROVIDE TREATMENT, WHICH MAY INCLUDE ANESTHETICS, SEDATION, X-RAYS OR MEDIATION, WHICH MAY INVOLVE SOME RISK TO MY PET. I RELEASE ANY AND ALL LIABIIY AND WILL NOT HOLD THE DOCTOR(S), STAFF OR REPRESENTITIVES OF ALL VALLEY PET HOSPTIAL RESPONSIBLE. I UNDERSTAND THAT I WILL BE RESPONSIBLE FOR ANY/ALL FESS ASSOCIATED AS AGREED, I WILL BE RESPONSIBLE FOR THE COST OF THE SERVICES, COLLECTIONS AND/OR ATTORNEY'S FEES.

SIGNATURE OF OWNER OR AGENT