

Appointment

Schedule

Last name		First name	
Pet name		Breed/Description (if one of multiple pets)	
Drop-off date / /	Drop-off time 9: 10: 11: 12: 1:00 ---- Closed ---- 4: 5: 6:00		
Pick-up date / /	Pick-up time 9: 10: 11: 12: 1:00 ---- Closed ---- 4: 5: 6:00		
Emergency #		Alternate caretaker (if applicable)	

Office use only

_____ of _____

Main _____

Toy _____

Other _____

*Check-out time is 1 pm. **We are closed every day from 1-4 pm.** If you pick up after 4 pm, you will be charged for that night's boarding, **unless** your pet is bathed or groomed that day.*

Grooming

<input type="checkbox"/> Complete groom ¹ <input type="checkbox"/> Bath ¹ <input type="checkbox"/> Brush out only <input type="checkbox"/> Nails only <input type="checkbox"/> Flea/tick protection	
Details	

¹ All **complete grooms** and **baths** include brush out, nail trim & ear cleaning. Prices vary by groomer and may change from visit to visit, depending on such aspects as the current condition of the coat and the cooperation of the dog.

Feeding

<input type="checkbox"/> Pet's own food ²		<input type="checkbox"/> Meadowbrooke-supplied food	
Brand/Formula		Diamond [®] Maintenance (21-12-3)	
Description of container (e.g., original bag, plastic box with blue lid)		Pet's usual food at home (Brand/Formula)	
(circle one) ½ 1 1½ 2 2½ 3 3½ 4 4½ 5 5½ cups each meal			
(circle one) 1 2 3 meals per day			
Details (for feeding only, use reverse side for medications or supplements)			
Treats (include how much and when you treat) ³			

² Pet's own food is recommended for puppies and first-time boarders.

³ Treats will be given at our discretion.

Activities

<input type="checkbox"/> Hike	\$4	Frequency (circle one) 1x/day 2x/day EOD Other	Details
<input type="checkbox"/> Playyard	\$2	Frequency (circle one) 1x/day 2x/day EOD Other	Details
<input type="checkbox"/> Super Playyard	\$5	Frequency (circle one) 1x/day 2x/day EOD Other	Details
<input type="checkbox"/> Cuddle	\$5	Frequency (circle one) 1x/day 2x/day EOD Other	Details

Alternate the activities selected above

Belongings

<input type="checkbox"/> Collar	Description (e.g., red quick-release)
<input type="checkbox"/> Leash	Description (e.g., braided leather)
<input type="checkbox"/> Bedding	Description (e.g., fleece bed)
<input type="checkbox"/> Toys/Other	Description (e.g., green stuffed bear)

We do our best to ensure that all personal items are not damaged or lost, but we cannot guarantee that they will be returned in the same condition in which they arrived. Don't leave anything you can't live without!

Reminders

<input type="checkbox"/> Food allergies	<input type="checkbox"/> In heat/season (estrus)	<input type="checkbox"/> Destroys bedding
<input type="checkbox"/> Jumps or climbs fences	<input type="checkbox"/> Digs under fences	<input type="checkbox"/> Afraid of loud noises (thunder)
<input type="checkbox"/> People aggressive	<input type="checkbox"/> Dog aggressive	<input type="checkbox"/> Cat aggressive
Details (e.g., may jump fence during storms)		

Medication #1

Name of medication		Dosage	
Condition being treated			
Type of treatment <input type="checkbox"/> Topical <input type="checkbox"/> Oral <input type="checkbox"/> Eyes <input type="checkbox"/> Ears <input type="checkbox"/> Other _____			
When to administer <input type="checkbox"/> Every ___ hours <input type="checkbox"/> 1x/day <input type="checkbox"/> 2x/day <input type="checkbox"/> 3x/day <input type="checkbox"/> 4x/day <input type="checkbox"/> As needed <input type="checkbox"/> Other			
Last dose given Date / / Time : am pm		Next dose due Date / / Time : am pm	
Details (e.g., put pill in cheese and give before thunderstorms)			

Medication #2

Name of medication		Dosage	
Condition being treated			
Type of treatment <input type="checkbox"/> Topical <input type="checkbox"/> Oral <input type="checkbox"/> Eyes <input type="checkbox"/> Ears <input type="checkbox"/> Other _____			
When to administer <input type="checkbox"/> Every ___ hours <input type="checkbox"/> 1x/day <input type="checkbox"/> 2x/day <input type="checkbox"/> 3x/day <input type="checkbox"/> 4x/day <input type="checkbox"/> As needed <input type="checkbox"/> Other			
Last dose given Date / / Time : am pm		Next dose due Date / / Time : am pm	
Details (e.g., put pill in cheese and give before thunderstorms)			

Medication #3

Name of medication		Dosage	
Condition being treated			
Type of treatment <input type="checkbox"/> Topical <input type="checkbox"/> Oral <input type="checkbox"/> Eyes <input type="checkbox"/> Ears <input type="checkbox"/> Other _____			
When to administer <input type="checkbox"/> Every ___ hours <input type="checkbox"/> 1x/day <input type="checkbox"/> 2x/day <input type="checkbox"/> 3x/day <input type="checkbox"/> 4x/day <input type="checkbox"/> As needed <input type="checkbox"/> Other			
Last dose given Date / / Time : am pm		Next dose due Date / / Time : am pm	
Details (e.g., put pill in cheese and give before thunderstorms)			

Use additional sheets as needed for medications

Use diagrams below to indicate areas requiring topical medication.
 Also note any conditions (e.g., lumps, hot spots, injuries) of which we need to be aware.

