PAWSPICE
DROP OFF RELEASE

I, the owner, am leaving my pet at VCA Coast Animal Hospital under the care of the veterinary clinic PAWSPICE. I assume full financial responsibilities for all charges incurred.

PICK UP TIME: _____

☐ Please contact me prior to treatment for my pet today.
☐ I do not need to be contacted prior to treatment for my pet today.

Best Number for Contact: ( ) _____

Alternate Phone Number: ( ) _____

Pet's Name: _____

Owner's Name: _____

Signature: _____ Date: _____

Update for Doctor: ☐ Vomiting ☐ Diarrhea ☐ Lethargy ☐ Weight Loss
Normal Appetite: yes / no Medications Given Today: yes / no

Additional Comments: _____
_____
_____
_____

New Clients: Please fill out information below:

Address: _____
Number Street City Zip

Referred By: _____

Please Circle: Canine / Feline Sex: M / F Spayed / Neutered

Breed: _____ Color: _____ Birth Date:_____

Do you have copies of your pet's recent medical records, X-ray's, & blood tests?
Yes / No