



VETERINARY TREATMENT AUTHORIZATION

Veterinary Hospital

Address

Phone

Medical History:

Name	Age	Sex	Species	Medications	Diet Limitations

Surgeries: _____

Existing medical disorders: _____

Injuries: _____

Pet Sitter will notify Pet Owner as soon as possible if medical attention is necessary. In the event that **Owner cannot be reached** or time is of the essence, this form will stand as a record of Owner's wishes.

Please indicate answers that apply

Yes No If my Pets need medical treatment, I agree to reimburse the Veterinarian for services rendered up to \$_____ for each pet

Yes No I agree to reimburse the Veterinarian for all costs they deem necessary to make my pet(s) well (If yes, must contact client for authorization.)

Yes No If my pet(s) are suffering from a TERMINAL illness or injury, the Pet Sitter will contact me first. If, however, I cannot be reached and my pet(s) are suffering, I give permission to the Veterinarian to euthanize them (If yes, must contact client for authorization.)

Additional comments

I hereby authorize my Pet Sitter or one of their representatives to seek medical treatment for my pets during my absence. This agreement applies to all the pets in my household now and in the future.

Pet Owner (print full name)

Pet Owner (Signature)

Date