

**Pet /Owner ID Form [Attach to pet crate] Date:**

**If possible: Attach Photo of Pet**

<b>Pet Owner:</b>	<input type="text"/>	<b>Telephone Numbers:</b>
<b>Address (line 1):</b>	<input type="text"/>	<b>Home:</b> <input type="text"/>
<b>Address (line 2):</b>	<input type="text"/>	<b>Work:</b> <input type="text"/>
<b>City, state, zip:</b>	Boulder, CO	<b>Mobile:</b> <input type="text"/>
<b>Email #1:</b>	<input type="text"/>	<b>Other:</b> <input type="text"/>
<b>Email #2:</b>	<input type="text"/>	

<b>Pet Name:</b>	<input type="text"/>	<b>Species:</b>	<input type="text"/>	<b>Gender:</b>	<input type="checkbox"/> M	<input type="checkbox"/> F
<b>Breed:</b>	<input type="text"/>	<b>Date of Birth (approx):</b>	<input type="text"/>	<b>Neutered:</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>Color/Markings:</b>	<input type="text"/>		<b>Micro Chip:</b>	<input type="checkbox"/> Y/N	<b>Brand:</b>	<input type="text"/>
<b>Wearing Collar w/ ID tags?</b>	<input type="text"/> <i>Explain if other than collar w/ tags</i>		<b>Chip #:</b>	<input type="text"/>		

<b>Rabies Vaccination #:</b>	<input type="text"/>	<b>Date of Rabies Vaccination:</b>	<input type="text"/>
<b>Other Vaccination/Shot:</b>	<input type="text"/>	<b>Date:</b>	<input type="text"/>
<b>Other Vaccination/Shot:</b>	<input type="text"/>	<b>Date:</b>	<input type="text"/>

<b>Medical Condition:</b>	<input type="text"/>		
<b>Medication:</b>	<input type="text"/>	<b>Dosage:</b>	<input type="text"/>
<b>How to administer meds (please describe):</b>			
<input type="text"/>			

<b>Other medical issues, special needs, special diet, etc:</b>
<input type="text"/>
<b>Diet and Feeding Schedule:</b>
<input type="text"/>
<b>Off limits (please do not feed or expose my pet to):</b>
<input type="text"/>
<b>Food and/or Drug Allergies:</b>
<input type="text"/>

<b>Vet Name:</b>	<input type="text"/>	<b>Work:</b>	<input type="text"/>
<b>Address:</b>	<input type="text"/>	<b>Mobile:</b>	<input type="text"/>
<b>City, state, zip:</b>	<input type="text"/>	<b>Other:</b>	<input type="text"/>

<b>Alternative Pet Care Giver:</b>	<input type="text"/>	<b>Home:</b>	<input type="text"/>
<b>Address:</b>	<input type="text"/>	<b>Work:</b>	<input type="text"/>
<b>City, state, zip:</b>	Boulder, CO	<b>Mobile:</b>	<input type="text"/>

<b>Medical Care:</b> If your pet is injured, do you authorize an available veterinarian to provide medical treatment?
<b>Yes:</b> <input type="checkbox"/> <b>No:</b> <input type="checkbox"/> <input checked="" type="checkbox"/> I will reimburse any expenditures up to Max. Amt: \$ <input type="text"/>
<b>Chemical Restraint:</b> If necessary for treatment or safety, do you authorize available licensed veterinarian to administer chemical restraint (sedative)? <b>Yes:</b> <input type="checkbox"/> <b>No:</b> <input type="checkbox"/>

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