Medication Form

Pet's Name _____ **Last Name** _____

Pet Parent _____ **Date** _____

Is your pet allergic to any food (human or pet)? □ Yes □ No

If yes, what?

_____

Total # of medications

_____

Medication Name			Verified medication (staff initials)	
For what condition/ailment is the pet being treated?				
Is there any special way that you give your pet medication?				
Type of medication	□ Ointment	□ Oral	□ Other, specify	
Is medication administered regularly or on an "as needed" basis?	□ Regularly	AM Amount	Noon Amount	PM Amount
	□ As Needed	If "As Needed," specify the maximum daily dosage/frequency.		

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