

BULLARD ANIMAL HOSPITAL
5700 POWDER SPRINGS RD
AUSTELL, GA 30106

DR. DANA SALMON DR. WHITNEY HALE DR. JEANNE GRIM

EMERGENCY CONTACT FORM

PATIENT(PET)

CLIENT(OWNER)

DATE

I, _____, understand that I am leaving _____ in the care of the doctors at Bullard Animal
CLIENT PET
Hospital. I, hereby, authorize the doctor on duty(and assistants the doctor may designate)to administer treatment and medication as is considered therapeutically or diagnostically necessary or appropriate on the basis of findings during the course of boarding of the above described animal. I also consent to the administration of such anesthetics and surgery as are necessary and appropriate under the circumstances. I assume financial responsibility for all charges incurred to the patient, and authorize direct payment to Bullard Animal Hospital. I understand that Bullard Animal Hospital is not staffed 24 hours.

****I also understand that if my pet has fleas, a flea prevention will be applied at an additional charge to me.(\$25.00)___initial**

****We cannot be responsible for lost leashes, blankets, toys, etc. If they are valuable please consider leaving them at home. ___initial**

****I understand that it is a criminal offense to abandon an animal at a veterinary facility. If my pet is left 7 days past the pick-up date and no contact can be made or I am unable to pay my bill in full, I realize I will be given 10 days to pick-up my animal or be charged with abandonment at which point my animal will become the property of our facility. _____initial**

Signature of Owner

Emergency Phone Number

FEEDING INSTRUCTIONS FOR MY PET(S):

If this section is left blank, we will feed your pet according to our standard which will be an appropriate amount based on body weight and only once daily.

BELONGINGS/MEDICATIONS:

