



Wellness and Vaccination Clinic Community Outreach Project

Client Information:

Date: _____ Parking # _____ Appt. Time: _____

Name: _____ Spouse/Partner/Co-Owner Name: _____

Street Address: _____ Apt/Lot #: _____

City: _____ State: _____ Zip Code: _____

Mobile Phone #: _____ Home Phone #: _____ Email: _____

Patient Information (please fill out one per pet):

Pet's Name: _____ Date of Birth/Approximate Age: _____

Species (please circle one): Dog Cat Breed: _____

Sex (please circle one): Male Female Unsure Spayed/Neutered (please circle one): Yes No Unsure

Color: _____ If cat, declawed (please circle): Yes/2 ft Yes/4 ft No Unsure

Does your pet requires a muzzle to be examined: Yes No Unsure

Patient History Information (please fill out one per pet):

How long has this pet been in your care? _____ Last known vet visit? _____

Previous or current veterinarian? _____ Vet Phone #: _____

What vaccines/tests does your pet need today? Please circle: For cats: Rabies FVRCP Leukemia FeLV/FIV test Fecal/deworm Microchip

For dogs: Rabies DHPP DHPPL Lepto Oral Bordetella Heartworm/Tick Disease test Fecal test/deworm Microchip Unsure

Any previous illness/injury with your pet? _____

Any known reaction to vaccines (soreness, lameness, weakness, vomiting/diarrhea, itching, facial swelling, shock, etc.):

Yes No Unsure If so, please specify: _____

Does your pet need to be treated with a "premedication" before receiving vaccines? Yes No Unsure

Does your pet have allergies (food, environmental, medication, etc.)?: Yes No Unsure If so, please specify and type of reaction: _____

What food do you feed your pet? Dry _____ Canned _____ Treats _____

How is your pet's appetite? Normal Decreased Increased Unsure Other _____

How is your pet's drinking? Normal Decreased Increased Unsure Other _____

Does your pet vomit? Yes No Unsure If so, how frequent? _____ Last episode: _____

Does your pet have diarrhea? Yes No Unsure If so, how frequent? _____ Last episode: _____

Your pet's urination habits? Normal Increased Decreased Inappropriate (accidents/markings) Unsure

Does your pet cough/sneeze (out of their "normal")? Yes No Unsure If so, how frequent? _____

Any concerns with pet's skin, ears, feet, hair coat changes, new lumps, or changes in old lumps? Yes No Unsure

If so, what have you noticed? _____

Any change to your pet's energy level? Normal Increased Decreased Lethargic Other _____

Has your pet gained or lost weight unexpectedly? Yes No Unsure Last known weight: _____

Does your pet go to the groomer, dog park, boarding facility, or travel with you? Yes No Plan to in the future

Does your pet take heartworm prevention? Yes No Unsure If so, what brand? _____

Do you need a written prescription today for your pet's heartworm medication refill? Yes No

Does your pet take flea and tick prevention? Yes No Unsure If so, what brand? _____

Do you need a written prescription today for your pet's flea and tick medication refill? Yes No

What other prescription medications, supplements, or over-the-counter medications do you give your pet? Please list:

Consent Form for Examination, Vaccination, and/or Treatment

I, the undersigned owner, agent of the owner, or Good Samaritan responsible for seeking veterinary care for the pet identified above, certify that I am _____/I am not _____ (initial one) eighteen years of age or over. I consent to the examination, vaccination and/or treatment of this pet by Dr. Kathleen Corbett, DVM at KALAMAZOO ANIMAL RESCUE (KAR) WELLNESS AND VACCINATION CLINIC. I also agree that the attending veterinarian will provide vaccinations and/or prescribe medication for, or treat, if needed. I understand that some risks always exist with vaccinations and/or medications, and that I am encouraged to discuss any concerns I have about those risks with the attending veterinarian before the procedure is initiated. Should some unexpected life-saving emergency care be required, and the attending veterinarian is unable to reach me, I give my permission for the attending veterinarian to provide such treatment, and I agree to pay for such care. If emergency care cannot be provided for any reason by the attending veterinarian, I understand a referral to the VCA Southwest Michigan Animal Emergency and Referral Center at 104 W. Cork St., Kalamazoo, MI, 49001 (phone # 269-381-5228) will be recommended for my pet at any time. (Initial _____)

I understand that my pet's participation in the KALAMAZOO ANIMAL RESCUE WELLNESS AND VACCINATION CLINIC is for wellness and vaccination services only. If my pet is deemed unhealthy by the attending veterinarian due to a known or unexpected illness, injury, or other condition(s), Dr. Kathleen Corbett, DVM and the KALAMAZOO ANIMAL RESCUE WELLNESS AND VACCINATION CLINIC has the right to refuse administration of vaccines, treatment, and/or other medications until the pet is deemed healthy or stable by the attending veterinarian or by the pet's regular DVM (if one exists). (Initial _____)

I have read, understand, and will abide by the COVID-19 protocols (as posted at www.kalamazooanimalrescue.org and at the time of appointment check-in) for the protection of myself, the attending veterinarian, and any assistants/volunteers for the KALAMAZOO ANIMAL RESCUE WELLNESS AND VACCINATION CLINIC. Refusal of services at any time by attending veterinarian and/or any assistants/volunteers may be rendered if COVID-19 protocols are not followed accordingly. (Initial _____)

I understand that an estimate of the costs for veterinary services will be provided to me before services are rendered (as posted on KAR website at www.kalamazooanimalrescue.org and at time of appointment check-in). I agree to assume financial responsibility for any services performed, and will provide payment via cash or credit card (Mastercard, Visa, or Discover Card) at the time my pet is discharged from KALAMAZOO ANIMAL RESCUE WELLNESS AND VACCINATION CLINIC. I, also, authorize KALAMAZOO ANIMAL RESCUE to run my credit card (including over-the-phone transactions). (Initial _____)

Lastly, I understand that I brought my pet willingly and knowingly to KALAMAZOO ANIMAL RESCUE WELLNESS AND VACCINATION CLINIC. I will not hold KALAMAZOO ANIMAL RESCUE, Dr. Kathleen Corbett, DVM, any of the assistants/volunteers, or their affiliations responsible for any costs, damages, or other liabilities in the event of any illness, injury, adverse reactions, lost/missing, or death of my pet should result due to my pet's participation in the KALAMAZOO ANIMAL RESCUE WELLNESS AND VACCINATION CLINIC at my request from and including this day noted below. (Initial _____)

By signing below, I have read, agree, and accept the terms and conditions noted above.

Signature of Owner or Agent _____ **Initials of Owner or Agent** _____

Printed Name of Owner or Agent _____ **Date** _____

Payment Information: Payment is due at time of service via Cash, Visa, Mastercard, or Discover Card. No checks please! 😊

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Wellness and Vaccination Clinic

Community Outreach Project

Patient Wellness Report Card

Date: _____ Parking Lot #: _____ Appt Time: _____

Client/Patient Information:

Client Name: _____ Phone Number: _____

Address: _____

Patient Name: _____ DOB/Age: _____ Species: Canine Feline

Breed: _____ Sex: F/I F/S M/I M/N Color: _____

Patient Examination: Vital Signs

Weight: _____ lbs. BCS: ____/9 Temp: _____ °F HR: _____ bpm RR: _____ brpm MM: _____ CRT: _____ sec

Patient Examination: Body Systems Assessment

- 1. **General Appearance** Normal Abnormal Not Able to Examine Not Examined
Comments: _____
- 2. **Eyes** Normal Abnormal Not Able to Examine Not Examined
Comments: _____
- 3. **Oral Cavity/Teeth:** Normal Abnormal Not Able to Examine Not Examined
Comments: _____
- 4. **Nose/Throat:** Normal Abnormal Not Able to Examine Not Examined
Comments: _____
- 5. **Ears:** Normal Abnormal Not Able to Examine Not Examined
Comments: _____
- 6. **Heart:** Normal Abnormal Not Able to Examine Not Examined
Comments: _____
- 7. **Respiratory:** Normal Abnormal Not Able to Examine Not Examined
Comments: _____
- 8. **Abdomen:** Normal Abnormal Not Able to Examine Not Examined
Comments: _____
- 9. **Musculoskeletal:** Normal Abnormal Not Able to Examine Not Examined
Comments: _____
- 10. **Lymph Nodes:** Normal Abnormal Not Able to Examine Not Examined
Comments: _____
- 11. **Urogenital:** Normal Abnormal Not Able to Examine Not Examined
Comments: _____
- 12. **Integumentary/Skin:** Normal Abnormal Not Able to Examine Not Examined
Comments: _____
- 13. **Rectal Exam:** Normal Abnormal Not Able to Examine Not Examined
Comments: _____

Patient Vaccinations and Testing:

Canine Vaccines/Test:	Given	Not Given	Due Date
• Exam	<input type="checkbox"/>	<input type="checkbox"/>	_____
• Rabies (1yr. or 3yr.)	<input type="checkbox"/>	<input type="checkbox"/>	_____
○ Rabies Tag Number			_____
• DHPP (no Lepto)	<input type="checkbox"/>	<input type="checkbox"/>	_____
• DHPP w/Lepto	<input type="checkbox"/>	<input type="checkbox"/>	_____
• Lepto	<input type="checkbox"/>	<input type="checkbox"/>	_____
• Oral Bordetella	<input type="checkbox"/>	<input type="checkbox"/>	_____
• Microchip	<input type="checkbox"/>	<input type="checkbox"/>	_____
• Other _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
• Fecal Test (lab) (we will notify you of results)	<input type="checkbox"/>	<input type="checkbox"/>	_____
• Flex 4 HW Test	<input type="checkbox"/>	<input type="checkbox"/>	_____
○ Heartworm	Positive	Negative	
○ Lyme Disease	Positive	Negative	
○ Ehrlichia	Positive	Negative	
○ Anaplasma	Positive	Negative	

Affix vaccine labels here

Feline Vaccines/Test:	Given	Not Given	Due Date
• Exam	<input type="checkbox"/>	<input type="checkbox"/>	_____
• Rabies (1yr. or 3yr.)	<input type="checkbox"/>	<input type="checkbox"/>	_____
• FVRCP	<input type="checkbox"/>	<input type="checkbox"/>	_____
• Feline Leukemia	<input type="checkbox"/>	<input type="checkbox"/>	_____
• Microchip	<input type="checkbox"/>	<input type="checkbox"/>	_____
• Other _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
• Fecal Test (lab) (we will notify you of results)	<input type="checkbox"/>	<input type="checkbox"/>	_____
• Abaxis FeLV/FIV	<input type="checkbox"/>	<input type="checkbox"/>	_____
○ FeLV	Positive	Negative	
○ FIV	Positive	Negative	

Affix vaccine labels here

Found Animals Microchip:

To register: visit www.foundanimals.org

Affix Found Animals Microchip Label Here (if done)

DVM Signature _____

Dr. Kathleen Corbett, DVM, CVA
Dr. Carissa Coulson, DVM

MI License No. 6901005391
MI License No. 6901010171

Signs of Vaccination Reaction:

Vaccine reactions are not common but can occasionally occur and could be life-threatening. Injection site soreness, redness, itchiness, decreased activity, decreased eating, or low-grade fever are most commonly seen, not life-threatening, and will usually subside in 24-48 hours. However, more serious reaction can occur and required veterinary care. These signs could develop within minutes to 24 hours after vaccination and signs include swollen or puffy face/eyes/lips, hives or bumps over the body (usually itchy), sudden vomiting/diarrhea, sudden coughing, difficulty breathing, gray or white gum color (lift lip to check), or sudden fainting/collapse, weakness or disorientation. If any of these signs occur, please call VCA Southwest Michigan Animal Emergency and Referral Center 24/7 at **269-381-5228**.

Invoice Total: _____

Paid: Cash Visa Mastercard Discover

Recheck Appt Needed: Yes No _____

Appointment: _____

Thank You for Visiting KAR Wellness and Vaccination Today! 🐾