A Dog's Dream "The Pet Salon"

MEDICATION RELEASE FORM

This form ***MUST BE*** filled out and submitted along with ***YOUR*** medications.

All medications must be supplied by owner of pet.

1. Name of condition medicine is prescribed for._____
2. Name of medicine and dosage for pet._____
3. When does pet get medicine?

   Circle/Complete one AM PM ___ times per day Other_____

4. Does pet need to eat prior to dose? YES NO (CIRCLE ONE)
5. If YES, How long after eating before giving medicine? _____
6. If INJECTION, what is the prescribed dosage to be given? Please mark syringes at prescribed dose.
7. Does medication require refrigeration? YES NO (CIRCLE ONE)
8. How many doses will pet receive while in our care? _____

NAME OF VET CLINIC AND DOCTOR PRESCRIBING MEDICATION:

_____

Phone # of Clinic ( ) _____

By completing and signing this form, I release A Dog's Dream "The Pet Salon" and any and all of its employees from any liabilities that could occur from pet receiving this medication as directed.

Pet's Name_____

Owner's printed name_____

Owner's Signature_____

Date_____

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