

THE DOG EAZE INN MEDICATION INSTRUCTIONS AND RELEASE FORM

Medication Name	Dosage	Type of Medication oral, pill, eye drops etc.	Refrigeration required YES / NO	Instructions:	Qty. to be left upon arrival	Begin Date	End Date	Reason for Medication	Potential Side Effects/Adverse Reactions
1.									
2.									
3.									
4.									
5.									

Treatment Order in the event of an adverse reaction(s): (Attach additional sheet or use the back of this form if necessary)

I request that The Dog Eaze Inn give the above medication to my pet while staying at The Dog Eaze Inn. I understand there will be an additional charge added to the daily lodging rate for this service. I agree not to hold the staff or facility responsible for any undesired reaction which may occur from this medication. I agree to pay for any veterinarian services The Dog Eaze Inn feels necessary or needed while my pet is in the care of The Dog Eaze Inn. If any of my pets becomes ill or is injured, I request that The Dog Eaze Inn take the pets to:

Veterinary Office Name: _____ **Alternate Veterinary Office Name:** _____
Address: _____ **Address:** _____
Phone Number: _____ **Phone Number:** _____

I give permission to The Dog Eaze Inn to approve treatment up to \$ _____ . I will assume full responsibility upon my return for payment and/or reimbursement for veterinary services rendered up to the above stated amount.

*If neither of the veterinary offices named above is available, I authorize **The Dog Eaze Inn** to take my pet/s to another veterinary office for treatment. I understand that **The Dog Eaze Inn** cannot be held responsible for the results of the veterinary treatment or the loss of my pet. This agreement is valid starting on the date below whenever **The Dog Eaze Inn** cares for my pets.*

Owner's Signature: _____ **Date:** _____ **Owner's Name (please print):** _____