MEDICATION FORM

Pet's Name: ______________________________

Pet Parent Signature: ____________________ Date: __________

Phone Number: ______________________________

Is your pet allergic to any food, human or pet? ○ Yes ○ No

If yes, what? ______________________________

Medication Name:

Verified medication as acceptable: ____________________

GSA Initials: ______________________________

For what condition/ailment is your pet being treated?

____

Is there any special way that you give your pet medication?

____

Please verify type of medication:

Ointment: ______________________________

Oral: ______________________________

Other; Specify: ______________________________

Is this medication to be administered regularly or on an "as needed" basis?

Regularly: ______________ Scheduled: ______________

AM: __________ Amount: ______________________

NOON: __________ Amount: ______________________

PM: __________ Amount: ______________________

As Needed ______________________________

If you selected "as needed" - Specify the maximum daily dosage/frequency:

____

Please turn over...

To be completed by a senior A Round of A Paws associate or manager:

Indicate the check-in and check-out time in the "Notes" section below. Mark "NA" in each applicable time slot where the pet did not receive medication (at the scheduled time to be administered or assessed) due to check-in and/or check-out times. Include the exact time the medication was administered and the initials of the person administering it under AM/Noon/PM. Pets receiving medications "As Needed" must be evaluated at a minimum of three times daily: AM/Noon/PM and confirm that the maximum daily dosage/frequency has not been exceeded prior to medicating.

Pet's Name: ______________________________

Bin Number: ______________________________

Room Number: ______________________________

Check-In Date: ______________________________

Check-Out Date: ______________________________

Manager Initials: ______________________________

Month: ______________________________

Date: ______________________________

Med(s): ______________________________

AM: ______________________________

PM: ______________________________

Notes: ______________________________

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Check-In Time: ______________________________