



# Glass City Dog Park Medical History Information

Dog owners, please complete the owner information section only.

Veterinary professionals, please complete the dog information, vaccination history veterinary hospital information and signature sections. Please return this form via postal mail to the address listed below, scan and email to: [membership@GlassCityDogPark.org](mailto:membership@GlassCityDogPark.org)

Please complete a separate medical history information form for each dog.

### Owner Information

|                 |               |       |     |
|-----------------|---------------|-------|-----|
| Name(s)         |               |       |     |
| Mailing Address | City          | State | Zip |
| Daytime Phone   | Evening Phone |       |     |

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### Dog Information

|       |           |        |   |
|-------|-----------|--------|---|
| Name  | Breed     | Gender | Weight  |
| Color | Birthdate | Age    | <input type="checkbox"/> Spayed <input type="checkbox"/> Neutered |

### Vaccination History

| Rabies  |         | DHLPP      |         | Bordetella |         |
|---|---------|------------|---------|------------|---------|
| Date Given  | Expires | Date Given | Expires | Date Given | Expires |
| Please note if titers were drawn in lieu of vaccinating |         |            |         |            |         |
| Additional observations or notes (optional)             |         |            |         |            |         |

### Veterinary Hospital Information

|                   |       |               |     |
|-------------------|-------|---------------|-----|
| Name(s)           |       |               |     |
| Address           | City  | State         | Zip |
| Veterinarian Name | Phone | Email Address |     |

*I hereby certify that the information listed above is accurate to the best of my knowledge.*

Veterinarian Signature \_\_\_\_\_

Date \_\_\_\_\_