Medication Form

Pet's Name: ______________________________ **Last Name:** _______________

Pet Parent (signature): ________________________________ **Date:** __________

Is your pet allergic to anything? (Including Food, Flea Control, or medications) ☐ Yes ☐ No

If yes, what? ____

Medication Name			Verified medication as acceptable: CCK Staff Initials:	
For what condition/ailment is the pet being treated?				
Is there any special way that you give your pet medication?				
Verify type of medication – count of prescription meds only	☐ Ointment Count:	☐ Oral Count:	☐ Other - Specify: Count:	
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?		

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For what condition/ailment is the pet being treated?				
Is there any special way that you give your pet medication?				
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