ANESTHESIA, SURGICAL, AND MEDICAL RELEASE

Pet Name: ____________________ **Owner Name:** ____

PROCEDURE: ____

Doctor performing procedure: Randall Jones Mavrich Rosen Shillito _________________________

Optional:

Microchip **$75** *Recommended for all pets. Microchip acts as permanent identification.*

(circle one) YES NO

When did your pet last eat? ____

Is your pet on any medications? □ Yes □ No If so, please list the medication information below:

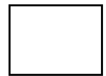
Medication	Dose	How often?	Time Last Given	Time Next Due

I, the undersigned, certify that I am the owner or authorized agent for the owner, of the animal described above. I authorize the Veterinarian on duty and technicians/assistants to perform the procedures listed above and on the estimate (if one was provided). This includes administration of pain medications, sedatives, and/or anesthetics, as well as any appropriate and necessary medical, radiological, surgical, nursing, diagnostic, and/or emergency care for the animal.

I have been advised as to the nature of the procedure(s) and the potential risks. I also understand that no guarantee of successful treatment can be made and I am responsible for any care and fees that may occur after the procedure, to include examinations, medications, bandaging, radiographs, and nursing care. I understand that the risks can include cardiac and respiratory arrest. In the event my pet's heart and/or breathing stops (cardiopulmonary arrest), resuscitation efforts will be undertaken by the doctor(s) and/or staff of Dupont Veterinary Clinic. Furthermore, I understand the doctor(s) and/or staff will immediately attempt to contact me via telephone at the telephone number(s) provided by me in the event of cardiac and/or respiratory arrest of my pet.

Contact Information:

I can be reached at the number below should the doctor have any questions during the procedure. I understand that if the doctor has made two or more attempts to call me at the number(s) listed below and I do not answer, I authorize the doctor to perform any medically necessary tests, diagnostics, radiographs, surgical, or dental care (including extractions). I also understand that I will be responsible for any charges that are performed that were deemed necessary.



_________________________________ _________________________________

First Phone Number Second Phone Number *DVC Witness*

_________________________________ ____

Signature of Owner/Agent Printed Name Date