LINDEN HEIGHTS ANIMAL HOSPITAL

PET CARE EMERGENCY AUTHORIZATION FORM

I, _____ give permission for the person(s) listed below to care for my pet(s) in my absence, and Linden Heights Animal Hospital has authorization to release any medical information to this person(s) about my pet(s) and may transport them to and from your hospital.

Person(s) taking care of pet during absence:
Name: _____Phone Number(s): _____.

Please Check one of the following statements:

- The agent above is responsible for my pet(s) while I am away and will be able to make **all decisions regarding veterinary care.**
- The agent stated above is responsible for my pet(s) while I am away. **For decisions regarding veterinary care, I wish to be contacted.** If I cannot be reached, I appoint the following person to act on my behalf:
  Name: _____Phone Number(s): _____.

Pet(s) Names:_____.
Departure Date: _____ Return Date: _____.
Contact Phone Number(s) while you are away:_____.

In the event of an emergency I authorize the following treatments to be performed:
_____ I DO authorize Linden Heights Animal Hospital to perform lifesaving treatments on my pet. This may include the administration of medication, chest compressions, oxygen, ventilation, and other emergency measures deemed medically appropriate. I understand that in this event I will be contacted when the veterinarian is able to step away from the pet. I assume financial responsibility of all lifesaving treatments.
_____ I DO NOT authorize Linden Heights Animal Hospital to perform lifesaving treatments on my pet. I authorize the attending veterinarian to minimize pain and suffering after the attempt to contact me. If the veterinarian is unable to contact me, I authorize the attending veterinarian to make the medically appropriate decision that may include euthanasia

In the event the attending veterinarian determines that my pet is suffering and/or is incurably injured(initial one):
_____I give my consent for euthanasia.
_____I do not give my consent for euthanasia.
If my pet should die or is euthanized, I prefer:
_____Private Cremation (Remains will be returned to me, usually takes 10-14 days.)
_____General Cremation (Remains are not returned.)
_____I request that the body be retained until I return.

FINANCES:
I agree that I will be fully responsible for all fees and charges and will pay for all charges incurred on my pet's behalf upon the day(s) of service. I authorize the use of my card number to be used only while I am away (see the dates above), by Linden Heights Animal Hospital, to pay for any medical expenses that my pet(s) may require. I am aware that my credit card number will be kept on file, but will be stored in a private and confidential manner. Please check one of the following:

- I authorize **any amount necessary** for the treatment of my pet at stated hospital.
- I authorize **a maximum of $_____** to be used towards my pet(s) care at this hospital.

_____ _____
Signature of Owner or Authorized Agent Date

274 Linden Drive, Winchester, VA 22601
540-667-4290

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