

# Veterinary Treatment Authorization & Consent Form

Primary Veterinary Information	
Name of Clinic:	
Address:	
City:	Phone:
Zip Code:	Fax:

To whom it may concern: During my absence a representative of Make My Day Please, LLC will be caring for my pet(s). I give Make My Day Please, LLC my permission to transport my pet(s) to you, my veterinarian (or to an emergency clinic). In the event I cannot be reached, I authorize Make My Day Please, LLC to act as an agent on my behalf regarding the medical care of my pet(s). I authorize veterinary treatment and accept full responsibility for charges incurred in the treatment of my pet(s), not to exceed the following amounts for each pet:

Pet Name	Description	Maximum Amount

List additional pets on reverse side if applicable.

Please initial the following:

\_\_\_\_\_ If above named veterinarian is not available, another veterinarian in his/her veterinarian group IS / IS NOT (circle one) acceptable.

\_\_\_\_\_ I understand that Make My Day Please, LLC assumes no responsibility for the loss of any pet and is released from all liability related to transportation, treatment and expense.

\_\_\_\_\_ I DO / DO NOT (circle one) authorize said veterinarian to euthanize my pet in extreme circumstances under his/her advisement after all responsible attempts have been made to reach me.

\_\_\_\_\_ The consent and treatment has no expiration date unless otherwise noted. A photocopy/facsimile of the signed consent shall have the same force and effect as the client/pet owner's original signature.

\_\_\_\_\_ If the veterinary office named is unavailable, I authorize Make My Day Please, LLC to take my pet to the veterinarian office or clinic of their choice for treatment.

This form will be retained on file and will be used to authorize veterinary treatment in the event that your pet(s) require(s) treatment while in our care during your absence, and we are unable to contact you at the time. Should you change veterinarians please notify Make My Day Please, LLC before service dates. **This form must be signed to authorize treatment.**

\_\_\_\_\_  
Client Printed Name

\_\_\_\_\_  
Signature/Date

\_\_\_\_\_  
Client Printed Name

\_\_\_\_\_  
Signature/Date