Fox Valley Therapy Dog Club

Annual Health Record

Owner
(Owner can fill out)

Name:
Address:

Phone:

Veterinarian
(Veterinarian stamp OK)

Business Name:
Address:

Phone:
STAMP:

Dog Information

Name:
Breed: Birth Date:
Gender: M F Neutered: Y N

Rabies Vaccination

Date administered: _____ 1 yr 3yr
County: Tag #:
If not given, reason:

Fecal Examination

Date performed: _____ NEG POS
If positive, treatment:

Physical Examination

Date of examination: Were results normal? YES NO

*If NO, are there any health issues that would prevent this dog from doing therapy work including public health issues such as external parasites, chronic respiratory or GI disease, etc, If so, please list:

Veterinarian's Signature

I have completed the vaccination, fecal exam and/or physical examination as stated above.
Print veterinarian's name:
Signature of licensed veterinarian: Date:

Please mail original to: Sue Schumann
8652 Doe Court, Yorkville, IL 60560
Or scan and email to: SueandRookie@aol.com

Revised/approved 5/2010