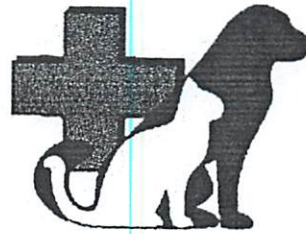


Feline Vaccination Record



ABC Pet Clinic

Last Name: _____ First Name: _____

Phone Number: _____ Mobile Landline DOB _____

Email: _____

Mailing Address: _____

City _____ Zip _____

Pets Name: _____

Breed: _____ Age: _____ Wt: _____

Sex: Male or Female (Circle one) Color _____

Neutered/Spay Yes or No (Circle one if applicable)

If you are not sure what vaccines are due and want us to administer vaccines that are due according to our computer records please initial here _____.

OR

I know I only want the following vaccines: Please initial here _____.

_____ \$25 Distemper Vaccine (FVRCP) 1yr/ 1st (or) 3yr

_____ \$25 Leukemia Vaccine (FeLV) Annual

_____ \$25 Rabies (Purevax) 1yr/ 1st (or) 3yr

I request and Authorize ABC Pet Clinic to vaccinate and/or provide a service for the above described animal. I understand that vaccines can cause adverse reactions in some animals. I hereby release ABC Pet Clinic and any employees from any claims arising out of or connected with giving these vaccinations and/or services.

Your Signature _____

Date _____