

# CHERISHED ONES PET SITTING

## Pet Profile

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Please fill out information for each pet.

Name of Pet: \_\_\_\_\_ Type of Pet: \_\_\_\_\_  
Breed: \_\_\_\_\_ Color: \_\_\_\_\_ Weight: \_\_\_\_\_  
Pet's age: \_\_\_\_\_ Pet's birthday: \_\_\_\_\_ Last Vaccination date: \_\_\_\_\_  
(You will be required to show proof of Rabies vaccination)  
Sex: Female: Spayed YES NO Male: Neutered YES NO  
Lic. # \_\_\_\_\_ ID Tags/Collar have current address & phone #: YES NO  
Micro Chipped: YES NO Is your pet: Indoor only Outdoor only Both  
Has your pet ever gotten out of your yard? YES NO If yes, please explain:

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### FEEDING INSTRUCTIONS: (please circle)

Frequency: AM PM Both Food is: Wet Dry Portion: \_\_\_\_\_  
Special feeding Instructions: \_\_\_\_\_  
Location of Pet Supplies: \_\_\_\_\_ Litter box located: \_\_\_\_\_  
Location of Cleaning Supplies (for pet accidents): \_\_\_\_\_  
Areas of home/neighborhood where your pet is not allowed: \_\_\_\_\_  
Pet's Favorite: Treats \_\_\_\_\_ Toys \_\_\_\_\_ Hiding places \_\_\_\_\_

Does your pet have any of the following: If YES, please explain:  
Allergies? YES NO \_\_\_\_\_  
Aggression towards people? YES NO \_\_\_\_\_  
Aggression towards other animals? YES NO \_\_\_\_\_  
Strong dislikes? YES NO \_\_\_\_\_  
Anxiety/Fears? YES NO \_\_\_\_\_

Does your veterinarian provide 24 hour emergency care? YES NO

If not, what emergency care facility should your pet be taken to:

Name: \_\_\_\_\_ Phone #: \_\_\_\_\_  
Address: \_\_\_\_\_

Directions from your home: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## Pet Profile

### **MEDICATION INSTRUCTIONS:**

Medical Problem: \_\_\_\_\_

Name and Type of medication: \_\_\_\_\_

Medication start date: \_\_\_\_\_ Medication end date: \_\_\_\_\_

Dosage: \_\_\_\_\_ Number of times per day: \_\_\_\_\_

Medical Problem: \_\_\_\_\_

Name and Type of medication: \_\_\_\_\_

Medication start date: \_\_\_\_\_ Medication end date: \_\_\_\_\_

Dosage: \_\_\_\_\_ Number of times per day: \_\_\_\_\_

Medical Problem: \_\_\_\_\_

Name and Type of medication: \_\_\_\_\_

Medication start date: \_\_\_\_\_ Medication end date: \_\_\_\_\_

Dosage: \_\_\_\_\_ Number of times per day: \_\_\_\_\_

Medical Problem: \_\_\_\_\_

Name and Type of medication: \_\_\_\_\_

Medication start date: \_\_\_\_\_ Medication end date: \_\_\_\_\_

Dosage: \_\_\_\_\_ Number of times per day: \_\_\_\_\_

Any further information/special instructions you would like to provide: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I certify that all of the information contained in this document is correct and true, and that I will notify Cherished Ones Pet Sitting of any changes that occur during any service period.

Client signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name: \_\_\_\_\_ Client #: \_\_\_\_\_