

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. # _____ (for ID only)
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 escaped from your yard or home YES NO If yes, please explain:

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 _____

Has your pet ever shown signs of: Describe (even if mild, or under extreme or unusual situations)

___ Allergies?	_____
___ Aggression towards people?	_____
___ Aggression towards animals?	_____
___ Strong dislikes?	_____
___ Anxiety/Fears?	_____

If your veterinarian does not provide 24 hour emergency care, to which facility should your pet be taken? Please circle one

CALIF. VETERINARY SPECIALISTS(CVS)
2310 FARADAY AVE., CARLSBAD
760-431-2273

VCA NORTH COAST ANIMAL HOSPITAL
414 ENCINITAS BLVD., ENCINITAS
760-632-1072

Directions from your home: _____

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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 #: _____