

REGISTRATION FORM

leighk9hydrotherapy

Owner's name _____

Address _____

Telephone No _____

Dog's Name _____

Breed _____ Age _____

Sex _____ Weight _____

MEDICAL HISTORY

Please give a brief description of problem (i.e. type of injury or required weight loss)

IN AN EMERGENCY

Veterinary's Name _____

Address _____

Telephone _____

Insurance Company (where applicable) _____

Policy No. _____

DISCLAIMER

I declare that I am the legal owner of the dog named above and that the information given is full and correct. I have read, understood and fully accept the Leigh K9 Hydrotherapy terms and conditions.

Signed: _____

Date: _____