CERTIFICATE OF VACCINATION – DONATION#______

OWNER PRINTS IN YELLOW HIGHLIGHTED FIELDS FOR 1ST ANIMAL JUST NAME FOR SUBSEQUENT PETS; RED FIELDS P-AHS FILLS IN.

Date of Rabies Vaccination: ________________ **Next Rabies Due On:** ______________ **Rabies Tag No**: ___________

VETERINARY CLINIC
Phoenix-Agape Humane Society
Richard H Harlow, DVM
PO Box 3303
Collegedale, TN 37315
423-800-5999

OWNER OF ANIMAL-Fill address for one pet
Name: ____
Address: ____
City ______________________________ **ST** ____ **Zip** _________
County: ______________ **Phone:** ________________________
Email: ____

This is to certify… **THAT I HAVE VACCINATED AGAINST RABIES THE ANIMAL DESCRIBED BELOW.**

Patient information... PATIENT: ___________________________ **Circle Species: Dog or Cat BREED:** ___________
WEIGHT: ___________ **CIRCLE SEX: M-MN-F-FS AGE:** _________ yr. **Color:** ________________

Signed Richard H Harlow, DVM **License:** 5654

Circle Vaccinations you want: ***RABIES*** **Vaccine: Manufacturer: B-I; SER #1213226A SubQ Killed virus**

DOG: ***Distemper-Parvo*** ***Bordatella-Kennel Cough*** **CAT:** ***Distemper-upper respiratory virus***

PROBLEMS; circle any that apply: Eyes (runny eyes-excess tears, sight, red, painful, pawing at, blind); **Ears** (digging at, odor, painful, dirty); **Nose** (runny nose, sneezing); **Mouth & Throat** (gagging, dif. swallowing, bad breath, dif. Chewing Excessive drooling, broken or missing teeth); **Gastro-intestinal** (not eat, vomit, diarrhea, swollen abdomen, constipation, worms); **Respiratory** (cough, dif. Breathing, blue, excessive panting); **Genital-Urinary** (any change in drinking or urinating or vaginal/penis discharge); **Musculoskeletal** (Limping, can't jump, sore joints); **Skin** (any itching, hair loss, fleas, ticks, dandruff and/or lumps); **Lymph Nodes** (lumps or bumps under skin); **Neurological** (behavior changes, changes in activity, seizures); **Any allergies** – (If over 1.5 yr. old Fleas, skin, food, etc?); **On any medicines** (HW prevention, any antibiotics, pain meds, etc); **HW prevention**- none if none: _____________ **What meds**: _____________

Any recent treatments (fleas or other) _________________

Explain any items circled above: ____

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Doctor Wellness Screening Exam:

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Handouts (circle handouts to be emailed): Ears; Dental; Fleas; Allergies; Other ____________