



LEARNING AND WELLNESS CENTER
 5800 Commerce Blvd. Rohnert Park,
 CA 94928 • 707-861-0235
 www.4Pawscenter.org

Canine Medical History for _____

Breed _____ Color _____

Owner's Name _____

Address _____

City, ZIP _____

Date _____

Dear Veterinarian:

Your client is applying to be a canine social therapy team with his/her dog to work with people in healthcare and/or educational settings. Please verify that the dog is in good health and is current on vaccinations by filling out this form. If you have any questions or concerns, do not hesitate to contact our volunteer staff. Thank you for your time.

Dog's DOB (or approximate age): _____ Weight: _____ Gender: M F Spayed/Neutered: **Yes No**

County and License No: _____

Rabies (please include copy of Rabies Certification)

Rabies Date _____ Next vaccination due: _____

DHPP Date _____ Next vaccination due: _____

Bordatella (at Veterinarian's discretion) Date _____

Corona Virus (at Veterinarian's discretion) Date _____

Is your patient on Flea/Tick Preventative? **Yes No** Heartworm Preventative: **Yes No**

If your patient is not on Flea/Tick/Heartworm preventative, date of last fecal float or deworming: _____

Has your patient been diagnosed with any of the following (please check if YES):

- Campylobacteris
 Yersoniosis
 Salmonellosis
 Cutaneous demtophyte infections
 Nematode infestation
 Leptosporis
 Canine brucellosis
 Resistant Staphylococcus

if YES, has your patient undergone successful treatment and is now safe to visit patients and/or children? Yes No

Please describe the general health and temperament of your patient and any health issue not included above.

Veterinarian (please print) _____ Signature _____

Address, City, ZIP _____ Phone: _____