

VETERINARY CONSENT FORM

Canine Massage Therapy

Ros Collinson Dip.CMT

| | |
|---|---------|
| Date: | |
| Owner's Details | |
| Name: | |
| Address: | |
| Postcode: | |
| Tel: | Mobile: |
| Email: | Fax: |
| Details of Dog | |
| Name: | Breed: |
| Age: | Weight: |
| Sex: | Colour: |
| <i>I/we declare that I/we are the legal owners of the dog named above and that all information given is correct. I/we give consent for the dog to receive massage therapy treatment. I/we have read and accept all the terms and conditions as stated below.</i> | |
| Owner's Signature: | Date: |
| Terms and Conditions of Treatment | |
| <ul style="list-style-type: none">▶ No dog will be treated without the prior consent of their Veterinary Surgeon.▶ Whilst every care is taken of the dog whilst having treatment it is carried out at the owner's risk.▶ Any dog with a contagious disease or an infection will not be treated and the therapist reserves the right not to treat the animal if vaccinations or worming treatments are not up to date.▶ Owners are required to notify the therapist if the dog's condition worsens during the course of treatments, or if the dog's Veterinary Surgeon advises that treatment should be stopped for any reason.▶ The therapist reserves the right to refuse treatment to any animal.▶ The therapist reserves the right to take photographs of the dog during the sessions for diagnostic reasons.▶ The therapist cannot be held responsible for any loss or damage to personal property during or after the therapy session. | |
| <p style="text-align: center;"><i>Please turn over for veterinary surgeon's form</i></p> | |

This page to be completed by your dog's Veterinary Surgeon

| | |
|---|-----------------|
| Name of Veterinary Surgeon: | Practice Name: |
| Address: | Practice Stamp: |
| Telephone: | Email: Fax: |
| Summary of dog's condition or injury: | |
| Are there any areas of caution or contra-indications? | |
| Details of current medication: | |
| Details of vaccinations: | |

I consent to this dog being given massage therapy treatment and would like a report to be sent to me when treatment is finished.

Signed: _____ Date: _____
(Veterinary Surgeon)

**When completed this form to be returned to Ros Collinson by fax on 01227 722135
or email to ros@canine-therapy.co.uk**