



The Fox Valley Therapy Dog Club  
Yorkville, Illinois

## Annual Therapy Dog Health Record

<p style="text-align: center;"><b>Owner</b> (Owner can fill this out)</p> <p>Name: _____</p> <p>Address: _____</p> <p>Phone: _____</p>	<p style="text-align: center;"><b>Veterinarian</b> (Veterinarian may use stamp instead of writing info)</p> <p>BusinessName: _____</p> <p>Address: _____</p> <p>Phone: _____</p> <p>STAMP: _____</p>
<p style="text-align: center;"><b>Dog</b></p> <p>Name: _____</p> <p>Sex: M F    Spayed    Neutered    Intact</p> <p>Breed: _____      Birth Date: _____</p>	

### ANNUAL REQUIREMENTS

<p style="text-align: center;"><b>Rabies Vaccination</b></p> <p>Date given _____ 1 yr    3yr</p> <p>County: _____ Tag # _____</p> <p>If not given, reason: _____</p> <p>_____</p> <p>_____</p>	<p style="text-align: center;"><b>Fecal Examination</b></p> <p>Date performed _____ NEG    POS</p> <p>If positive, specific results and treatment: _____</p> <p>_____</p> <p>_____</p>
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**Physical Examination**

Date of examination: \_\_\_\_\_ Were results normal?    YES    NO

\*If NO, are there any health issues that would prevent this dog from doing therapy work including public health issues such as external parasites, chronic respiratory or GI disease, etc, If so, please list:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Veterinarian's Signature**

I have completed the vaccination, fecal exam and/or physical examination as stated above.

Print veterinarian's name: \_\_\_\_\_

Signature of licensed veterinarian: \_\_\_\_\_ Date: \_\_\_\_\_

Please mail original to:      Diane Obey, Membership Coordinator  
2286 Highfield Lane  
Aurora IL, 60504

**Or** email a scanned copy to: [dianeobey@yahoo.com](mailto:dianeobey@yahoo.com)