Fox Valley Therapy Dog Club

Annual Health Record

Owner
(Owner can fill out)

Name:
Address:

Phone:

Dog Information

Name:
Breed: Birth Date:
Gender: M F Neutered: Y N

Veterinarian
(Veterinarian stamp OK)

Business Name:
Address:

Phone:
STAMP:

Rabies Vaccination

Date administered: ___________ 1 yr 3yr
County: Tag #:
If not given, reason:

Fecal Examination

Date performed: _________ NEG POS
If positive, treatment:

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 scan and email to: FVTDCMembership@gmail.com

Revised/approved 5/2010